The Clatterbridge Clinic LLP

Clatterbridge Cancer Hospital

Inspection report

Private Clinic - Level 1
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

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

Summary of findings

Our judgements about each of the main services

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

Summary of findings

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Summary of this inspection

Background to Clatterbridge Cancer Hospital

The service is a clinic for independently funded patients with cancer and is in the same building as the NHS specialist cancer trust in Liverpool. There is another service run by the same provider located on the Wirral and the two services work closely together. The service treats adults over 18 years of age. The service takes co -funded patients who are receiving treatment through the NHS but are paying for some elements of the treatment themselves, this is usually for medicines that have not yet been approved for their treatment by the National Institute of Health and Care Excellence. There are also a number of international patients who use the service. The service does about 30 consultations per month and 100 cancer treatments. The clinical staff are employed by the specialist cancer trust.

The service is owned by a private company but 49% of the profits are put back into the NHS.

There is a registered manager who has been in post for three months and the regulated activity for the service is treatment of disease, disorder or injury.

This location has not been inspected before

How we carried out this inspection

The service was inspected by an inspector and a specialist advisor with experience of working in cancer services. We visited the clinic on two occasions as there were no patients in the clinic during the first visit. We spoke with the clinic manager, the clinic services manager, two qualified nurses and a consultant oncologist. We observed the care and treatment of three patients and spoke with two patients and their relatives. We reviewed five patient records and asked for information from the service to review as part of our 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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust 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.

Our findings

Overview of ratings

Our ratings for this location are:

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

Medical care (Including older people's care)

Good

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

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

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone The mandatory training was comprehensive and met the needs of patients and staff. Staff from the service accessed the specialist cancer trust mandatory training.

Nursing staff received and kept up to date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training.

Staff received training in interacting with people with a learning disability and people with autism. Compliance with this training was at 100%.

The clinical services manager encouraged staff to take responsibility for maintaining their training. Training rates were at 100% for the nursing staff at the clinic.

The clinical services manager and the registered manager were aware of the training rates for the administration staff who were not employed by the NHS.

Medical staff received and kept up to date with their mandatory training. This was managed by the specialist cancer trust and the medical advisory board.

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.

Training rates for safeguarding children and young people and adults was at 100% for nursing staff. The clinical services manager and the registered manager were aware of the training rates for the administration staff who were not employed by the NHS. This included disclosure barring service checks.

Disclosure barring service checks were managed through the NHS specialist cancer service human resources department for all NHS staff. The service had a record of these checks and when they needed to be renewed.

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.

There was an NHS specialist cancer trust infection control policy which was in date and had a review date. Staff received infection control training on their induction and it was then refreshed every two years. Infection control was managed by the clinical services manager at an operational level and at a strategic level by the specialist cancer trust.

There was a hand hygiene strategy which referenced the World Health Organisation five moments for hand hygiene. The handwashing audit was at 100% for the last six months.

The clinic areas were extremely clean, and the clinic had comfortable chairs and sofas in patient areas which were clean and well-maintained.

Patients and visitor temperatures were checked as they came into the reception area. Patients completed lateral flow tests at home before their treatment. Staff said that they would not treat anyone who had Covid-19 until the virus had cleared.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that PPE was plentiful and that staff used it. When a patient received treatment there were notes in the patient records that appropriate PPE was worn.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw evidence of “I am clean stickers” on appropriate equipment.

Each staff member was fit tested for two types of mask in case there was a poor supply of one type of mask.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The daily cleaning list was completed when there were patients in the clinic, and we saw that these checks had been completed.

There was a rapid response team for cleaning that staff could access as necessary.

Environment and equipment

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

We saw maintenance and service records for equipment that was used in the clinic. All were up to date.

There were four spacious, well decorated treatment cubicles each with a reclining chair for patients receiving treatment. The chairs were heated so that patients using the cool cap could stay warm. A cool cap is a hat worn during some types of chemotherapy treatments to help to reduce hair loss. There were also additional chairs for anybody accompanying the patient.

Good

Medical care (Including older people's care)

The cubicles had an oxygen supply and suction, they could be curtained off for privacy, all the cubicles had their own call bell. Hand gel was available in each cubicle.

The nurses' station was in front of the cubicles with a good line of sight into the cubicles.

There were three consulting rooms, with a treatment couch in each. All had handwashing sinks. There was a dedicated phlebotomy room which had a handwashing sink. This was used to takes bloods from peripherally inserted central catheters and chemotherapy ports and redress them.

There was a resuscitation trolley in the main reception area which was easily accessible. The top shelf was checked daily when there were patients in the clinic receiving treatment. The drawers were checked weekly. We checked the trolley and its contents, and all were in date. We saw that the checks were recorded.

There was also an anaphylaxis kit, an extravasation kit, a spill kit and a sepsis response kit. We saw evidence that these were checked daily and that this was recorded. There was a blood glucose monitoring machine which was checked twice a week.

There were daily floor checks when the oxygen and suction were checked. The lights, treatment chairs, the cool cap machine, call bells by the patient chairs and the emergency call bells in the phlebotomy room and the patient toilets were checked. This was documented.

Sharps bins were not over filled, and staff disposed of clinical waste safely.

Assessing and responding to patient risk

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

The service used an early warning system (NEWS2) to monitor for deteriorating patients. There was also an electronic sepsis screening tool. There were triggers identified in the deteriorating patient policy so that staff were aware when they needed to refer for additional support.

The early warning scores training was completed every year and staff working in the clinic were up to date with their training.

Staff were trained in advanced life support skills and basic life support skills as appropriate. We saw that training was at 100% compliance.

There was a daily safety huddle which was documented. Items that were discussed included who would take responsibility for safeguarding, who would be the immediate life support lead, the basic life support lead, the anaphylaxis lead and the fire marshal. PPE was also discussed at the safety huddle.

Patients completed with staff a comprehensive pre- assessment before they started any treatment. This was a clinical needs assessment which included a full medical history, information about any allergies and social and psychological needs. Risk assessments were completed and reviewed during the patient's treatment.

There were systemic anti-cancer treatment assessments, height and weight for each patient, observations as baselines, observations during treatment and triage assessment logs. We saw that observations were recorded.

We saw on the electronic patient records that the observations were taken in a timely way and were thorough. The staff responded immediately if a buzzer or alarm went off during the patient's treatment.

Any patient suspected of having anaphylaxis received immediate treatment on site and was then transferred to the urgent and emergency care department of the neighbouring NHS acute trust. This could be done through a connecting corridor. Staff were aware of which treatments were more likely to cause anaphylaxis. Staff had received training on the symptoms of hypersensitivity to a treatment as compared to anaphylaxis.

If creatinine clearance levels were needed before treatment could commence there was a calculator in the records system and alerts would come up if patients were out of tolerance. Creatinine clearance is an indicator of renal function which is monitored during chemotherapy because some chemotherapeutic agents are excreted by the kidneys and are toxic to the kidneys. Staff would then speak to the pharmacists and the patient's consultant.

There was an immunotherapy toxicity service that could be accessed by the service that was provided by the trust.

Patients could access a help line triage service if they were unwell and were asked to telephone the line if their temperature went above 37.5 degrees centigrade. The call went through to the clinical decision unit at the cancer trust who would assess and advise the patient as necessary. This prevented unnecessary admissions to urgent and emergency care services.

Patients received information about the signs of spinal cord compression and what to do if they suspected they had symptoms.

Patients of child- bearing age were asked about possible pregnancy before each treatment was started.

There were emergency call bells in the patient toilets and all the clinical rooms.

Staffing

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

There was a band six nurse, two band five nurses and a health care assistant for the clinic. There was also a clinical services manager who covered both sites. The clinic rotated staff with the other clinic location based on the Wirral. This ensured that there were always enough nursing and support staff to keep patients safe.

Staff from the NHS specialist cancer trust could also cover absences such as annual leave and study leave. The clinical services manager could step in if there was unexpected sickness or absence. There were no vacancies at the time of the inspection. The clinic did not use any agency staff.

Nursing staff and support staff were employed by the NHS trust while administration staff were employed by a separate company.

Good

Medical care (Including older people's care)

Medical staffing

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

The care at the clinic was consultant led and all the consultants were employed by the NHS trust.

There was a consultant of the day and a consultant of the week for the NHS trust hospital and they covered the patients attending the private clinic if necessary.

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 records were comprehensive, and all staff could access them easily. There were two separate electronic systems used in the recording of patient's care and treatment.

We reviewed five records of patients attending the clinic and all had been completed fully.

Records we saw were comprehensive and all assessments and observations could be viewed when a patient was undergoing treatment. Notes could be added to records, but they could not be edited.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The clinic used the pharmacy service of the specialist cancer trust for their systemic anti- cancer therapies (SACT) and had access to the specialist pharmacy team.

There was an authority to prescribe chemotherapy/systemic anti -cancer therapy policy that was used by the specialist cancer trust and the clinic. This was guidance for the prescribing and review of chemotherapy and systemic anti- cancer therapies. For patients who were off protocol, who did not follow the established pathways for treatment, there was a systemic anti-cancer therapy algorithm/ protocol deviation policy. All prescribing was done through the electronic prescribing system.

The medicines administration record was part of the patient electronic record and was password protected. The prescription was recorded with any comments and alerts. All the treatments had policies attached to them with easy access links to doses, blood results and frequency of administration. There were pre- treatment checklists for all regimes.

Medicines were stored in a locked air -conditioned room and there was an electronic keypad to access the key cupboard. The temperature of the room was monitored and recorded. There was an emergency drawer that contained adrenaline, atropine, an anaphylaxis kit and a sepsis response box. These were checked every day.

The first cycle of SACT could only be prescribed by a consultant, future cycles of treatment could be prescribed by those authorised to prescribe.

Good

Medical care (Including older people's care)

There was a single staff checker for the SACT. This was in line with the medicines policy for the specialist cancer trust. Staff then checked details with patients including, name, date of birth and address and the details of the treatment that they would be receiving. There had not been any medicines incidents at the clinic.

There were medicines for the patients to take home following their treatment.

The clinical services manager was a trainee non- medical prescriber. Non-medical prescribing is the term used to describe any prescribing completed by a healthcare professional other than a doctor or dentist. They had been mentored by one of the consultant oncologists during their training. Both the consultant and the clinical services manager said that patients benefitted from this and the consultant said that this saved them time when they could be treating other patients.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. The service was part of the electronic incident system used by the NHS specialist cancer trust. Staff raised concerns and reported incidents and near misses in line with trust policy of the specialist cancer trust.

The service had no never events in the clinic.

The clinical services manager used the Wednesday safety huddle to share any learning from the week. Staff on both clinical sites were encouraged to put ideas and suggestions into a box on each site, this was then opened by the manager and the contents were discussed. We were given an example where blood bottles for clotting screens had not been filled properly. All incidents from the week were discussed at the Wednesday huddle.

Staff reported serious incidents clearly and in line with the specialist cancer trust policy. Less serious incidents were investigated by the clinical services manager for the clinic and more serious incidents were investigated by the chief nurse for the specialist cancer trust. There was feedback to staff about all incidents.

We were told of a "you said, we did" issue and the changes that had been put in place following comments from a patient.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

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

Good

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 protected the rights of patients subject to the Mental Health Act 1983.

Good

Medical care (Including older people's care)

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The NHS specialist cancer trust produced a National Institute for Health and Care Excellence (NICE) annual report. There was also a NICE assurance committee. NICE compliance was monitored through the specialist cancer trust divisional quality and safety meetings. In May 2022 there was 96% compliance with NICE guidance against the trust target of 90%. There was a trust non-compliance document with recommendations and reasons for non -compliance. This was managed through the medical advisory board.

The electronic patient record and the medicine administration record had links to policies, treatment regimes and any checks that needed to be carried out before treatment was started.

Some patients received treatment that was off protocol. Any consultant who wanted to use one of these treatments had to get approval from the members of the provider's medical advisory board to justify the treatment. The treatments were usually for medicines that were in the process of gaining approval from the National Institute for Health and Care Excellence.

Nutrition and hydration

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

The clinical assessment completed for each patient included details of food and nutrition and used the Malnutrition Universal Screening Tool if appropriate. Patients could be referred to the trust dietetic service if appropriate.

The clinical assessment included a section for patients with head and neck cancers and upper gastro-intestinal cancers who due to their treatment would require additional support with nutrition and hydration.

Patients were offered a range of meals and snacks during their treatments, these were purchased from retailers outside the NHS. If patients required a hospital stay in the specialist cancer trust they were given vouchers for food at the café.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

A pain assessment was completed as part of the clinical assessment process. Patients could be referred to the palliative care team at the specialist cancer NHS trust if necessary.

Patients were given pain relief as necessary but for ongoing issues they would contact their GP.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The NHS specialist cancer trust participated in relevant national clinical audits. Outcomes from the clinic patients fed into these audits which included the National Bowel Cancer Audit, National Prostate Cancer Audit, National Oesophago-Gastric Cancer Audit, the National Lung Cancer Audit and the National Audit of Care at the End of Life.

There was a National Systemic Anti-Cancer treatment body that published 30 day mortality benchmarking for a number of tumour groups. The mortality rates would cover all patients treated at the specialist cancer trust and the private clinic.

There was a mortality review process which was through the electronic incident reporting system and a mortality reduction strategy was in place. A structured judgement review form based on information from the Royal College of Physicians had been introduced for all in-patient deaths. There was also a mortality dashboard that had been in place since 2018 to give oversight of mortality at the specialist cancer trust. The consultants from the service used these processes for their patients if appropriate.

There were mortality review meetings to improve practice and to celebrate best practice. These meetings were multi-disciplinary and looked at 30 day mortality in all in-patient deaths, formal incident reported deaths and any concerns raised by individual consultants. The specialist cancer trust also produced a shared learning newsletter for all staff who worked at the NHS specialist cancer trust and at the service.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Nursing staff had completed or where in the process of completing their training from the United Kingdom Oncology Society (UKONS) training. This was the systemic anti-cancer treatment passport. There was a theory section and a practical assessment section with annual reaccreditation. The clinical services manager worked with staff to train and assess their competencies during and after their training. Staff could also access all the training provided by the specialist cancer trust.

Managers supported the nursing staff to develop through yearly, constructive appraisals of their work. We saw that all staff had an appraisal which was done by the clinical services manager.

Staff received training and achieved competencies in specific cancer modules and competencies including aseptic non touch technique, chemotherapy, extravasation and all nursing staff were trained in phlebotomy.

Nurses were encouraged to sit in with the consultant oncologists when they were discussing treatment with their patients. The clinical services manager said that this was beneficial to both the nurses and the patients. It was a learning experience for the nurses and often the nurses could answer patients queries about their treatment.

Patients had access to specialist cancer care nurses from the NHS specialist cancer trust. They also accessed specialist nurses from the referring independent hospital.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff learned skills and competencies with senior nurses acting as assessors.

Managers made sure staff received any specialist training for their role. Staff could access courses, conferences and training if managers considered that this was relevant for their work.

Multidisciplinary working

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

Good

Medical care (Including older people's care)

The oncology consultants worked with referring surgeons from other independent hospitals. They had practising privileges from the referring hospital so they could participate in the multi-disciplinary meetings where the treatment for patients was discussed and agreed by all the staff involved in the care and treatment of the patient. A consultant oncologist told us this worked well and helped to provide seamless care for the patients.

There was input to patient care from a range of health professionals as the patient underwent treatment. The pre-assessment form documented what the patient would need from professionals including dieticians, speech and language therapists, occupational therapists, physiotherapists, pharmacists and palliative care services. This was available from the specialist cancer hospital services. There was psychological support from dedicated psychologists for the service.

Patients were reviewed by consultants during their treatment.

Seven-day services

Key services were available five days a week to support timely patient care.

The service was provided Monday to Friday depending on patient needs. Staff would start early or late depending on the daily schedule.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. This was part of the pre-assessment process and patients were provided with resources such as recipe books to support their treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The service worked to the consent policy of the NHS specialist cancer trust.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. There was two stage consent, the first consent was with the consultant where patients were provided with information about treatment and a discussion of their options for treatment. The second was at the pre assessment stage before beginning any treatment and was confirmation that the patient still wished to proceed with treatment. This was completed by the nursing staff.

The service used E-consent, staff told us that this worked well. Staff clearly recorded consent in the patients' records.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. The service treated patients who lacked capacity. Staff told us that they would use the specialist cancer trust safeguarding team to support consent process for patients who lacked capacity.

Staff clearly recorded consent in the patients' records.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Good

Medical care (Including older people's care)

Staff knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards through the safeguarding team of the NHS specialist cancer trust.

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

Good

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 responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed that staff were very caring and formed close relationships with patients.

Staff tried to give continuity of care so that they were followed through from pre-assessment to treatment by the same member of staff if possible. This enabled staff to monitor patients physically and mentally and to pick up any emotional needs that they might be having.

Staff were able to give very personalised care to patients due to staffing numbers and the low numbers of patients attending the clinic. A patient told us that they had attended the Wirral service but had come to the Liverpool for some tests. As soon as they saw the clinic they asked to transfer as they loved the atmosphere and environment of the clinic.

We saw that all the staff at the clinic made drinks for patients and checked on their well- being during their treatments.

Patients were contacted by phone by the nurses to check on their progress between treatments and to identify any issues that they may be having.

Emotional support

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

There was psychological support for patients attending the service, this was specific to the service. All patients were offered the service as part of the pre-assessment process. We were given an example when the service had supported a patient with decision making regarding treatment; they had ceased treatment but then were able to continue treatment with support from the psychology service.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff supporting a patient who was having a “bad day”, they were empathetic and spent time with the patient listening to their issues and concerns.

A patient comment from the friends and family feedback was that staff were attentive and always listened. We spoke to a patient during our visit who said it was the amount of time that staff could spend with patients that made the difference.

Good

Medical care (Including older people's care)

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.

Staff made sure patients and those close to them understood their care and treatment. We spoke with a patient and their relative, the patient said that they liked their relative accompanying them to their treatments so they could observe what happened and this provided reassurance for the relatives.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Friends and family results from January 2021 to August 2022 indicated that 96.3% (444) of patients who completed the survey said the service was very good and 2.9% (13) said the service was good.

Comments included “really professional and friendly staff who are very good at their job”, “excellent and compassionate service” and “it was perfect”.

Patients could contact their consultant by phone to ask questions about their treatment. We saw that a consultant telephoned a patient during their treatment to ask how they were.

Staff supported patients to make informed decisions about their care. There was information available to all patients from the staff and charities involved in the care and treatment of patients with cancer.

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

Good

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

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

The service worked closely with the NHS specialist cancer trust to plan and deliver services for patients who were self -funding their cancer care. These patients were people from the local area, the United Kingdom and international patients.

Facilities and premises were appropriate for the services being delivered. The environment of the clinic was calm and peaceful, and the clinic was well designed. Furnishings were tasteful. Each of the four treatment areas was spacious and had treatment chairs for patients and comfortable chairs for patient’s relatives and friends. There was a television in each treatment area and all areas were airconditioned. The service supplied magazines of the patient’s choice.

The service had systems to help care for patients in need of additional support or specialist intervention. At the morning safety huddle staff identified patients who needed hoisting, interpreters, bariatric patients and any patient with communication issues.

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.

Good

Medical care (Including older people's care)

The service was located on the first floor of an NHS specialist cancer hospital. The lifts were accessible for wheelchairs and there were wheelchair accessible toilets in the clinic.

Staff supported patients living with dementia. The service treated patients with dementia but had few patients with a learning disability. There was a dementia box with included dementia signs for toilet doors and other support for patients undergoing treatment. The pre-assessment process was used to personalise treatment for every patient including those requiring additional support.

Interpreters could be booked through the specialist cancer trust systems as necessary. Information was available to all patients from the charities involved in the care and treatment of patients and carers living with cancer. it was not available in all languages but could be translated if necessary. It was also available in audio form.

The NHS specialist cancer trust could be used to support patients with specialist needs when necessary.

There were reserved slots for patients who required computerised tomography scans at the clinic with the specialist cancer trust.

A staff member had completed the mental health first aid training to provide support to both patients and staff.

There was a concierge service that liaised with the patient services co-ordinator to discuss any requirements that the patient might have to ensure that they could attend the clinic. For any overseas patients there were airport transfers. Hotels and apartments were used depending on the patient’s requirements and the service had accommodated pets in these quarters.

There was free car parking available to patients attending the service. Taxis and transport were provided individually to patients as necessary; these were individual drop offs and no group bookings.

There were overnight bags for patients who required an unexpected overnight stay containing a toothbrush, a hairbrush, toiletries, a towel and a word search. They were also given vouchers for the specialist cancer trust café.

Food was ordered from outside suppliers for patients attending the service . Patients could select any food that they wanted. The service provided insulated cups so that patients with neuropathy did not burn their fingers. Recipe books were also provided to support patients with specialist dietetic needs relevant to their treatment.

Patients who were using the cool cap received a pack with a detangle brush, a mirror and a headband. All patients received a welcome pack with hand cream, lip balm, a mirror and some hand gel. There were also complimentary peripherally inserted central catheter line covers to disguise the line.

All the staff at the service had chaperone training.

All patients could access services at the NHS specialist cancer trust for patients including charitable support services and wig services. They could also access the charitable centres that provide cancer support helping with money worries, relationship support, emotional support for patients and their carers and help patients to manage their symptoms.

Access and flow

People could access the service when they needed it and received the right care promptly.

Medical care (Including older people's care)

Managers monitored waiting times. From the period of 31 August 2021 to 16 August 2022 the shortest wait from referral to consultation was one day and the longest was 22 days. The average wait for treatment from 3 February 2021 to 18 August 2022 was 8.6 days.

On arrival at the service patients were seen promptly if they required phlebotomy services.

Non- attendance for treatment was reported as an incident and followed up with the patient as a matter of urgency.

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 included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them.

The clinic followed the NHS specialist cancer service complaints and concerns policy when dealing with any complaints and issues.

The clinic was a member of the Independent Sector Complaints Adjudication Service.

There had been no complaints about the service in the previous 12 months before the inspection. The clinic manager said that they spoke with patients during their treatments at the clinic and were able to deal with any issues that arose very quickly.

Any issues raised by patients were discussed at the daily huddle and if necessary, at the staff meeting. These meetings covered both the private clinic sites so that information was shared. We were given an example of feedback from a patient that had been used to change the service.

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

Good

Leadership

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

The registered manager worked for the private company that was the provider for the service. All the clinical staff were employed by the specialist cancer trust. The registered manager and the clinical services manager worked well together to provide effective leadership of the clinic. The clinical services manager worked at a strategic level but had excellent insight into the service and worked to support the clinical staff in service delivery.

Good

Medical care (Including older people's care)

The clinical services manager worked across the two clinical sites dividing their time between the two services. They had oversight of both services and staff meetings were held across both sites every six weeks. Staff meetings included clinical and administration staff.

There was leadership development for the clinical service staff and we saw that staff could progress through the service with training available. The clinical services manager was part of the nursing leadership forum in the NHS specialist cancer trust and was taking an organisational role in the organisation of the forum. This ensured that staff in the service were linked into the leadership programmes and opportunities in the NHS specialist cancer trust.

The clinical services manager attended the nurse leaders' forum at the NHS specialist cancer trust. This informed the manager about any issues in the trust that they could feed back to staff and to provide information about the private clinic to the wider nursing team. The agenda included incidents, near misses and complaints.

Vision and Strategy

The service was developing a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

The NHS specialist cancer trust and the service were new to the Liverpool site and occupied a new purpose-built hospital in the centre of Liverpool. Any strategy would support the development of cancer services across Merseyside and Cheshire using both the Wirral and Liverpool sites.

The registered manager was new to the service and was looking to develop the current strategy of the clinic. A strategy day was planned with executive representation from the NHS specialist cancer trust and the private provider of the clinic. This would allow development of a strategy in line with the strategy of the NHS specialist cancer trust and the wider health economy.

The service was developing a branding strategy to promote the work that they did and the relationship between the NHS specialist cancer trust and the service. The registered manager was involved in the induction of staff starting work at the NHS specialist cancer trust to inform them of the work of the clinic and its relationship to the trust.

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 culture of the service was open and staff could speak freely and raise concerns as necessary. The clinical services manager worked clinically and so was aware of any issues, they supported staff training and development and staff told us that they felt that they all worked well as a team. Staff rotated through the two services and staff were expected to work on both sites as necessary and were used to working together to provide good quality care.

Staff completed equality and diversity training as part of mandatory training and training rates were at 100%.

Staff we spoke with said that they enjoyed working for the service. They liked the fact that they were part of the NHS but delivered this service for self- funding patients.

Good

Medical care (Including older people's care)

We were given examples of staff development including the non-medical prescribing course for the clinical services manager. Staff were able to access training and conferences if it was relevant to their role. Staff could access the Freedom to Speak Up support of the NHS specialist cancer trust and were covered by the trust policy. If there were concerns from staff this would be fed back to the service from the Freedom to Speak Up team.

Governance

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

There were monthly meetings with the executive team from the specialist trust including the chief executive officer and the chief operating officer for the private clinic. This was the Clatterbridge private clinic board. Membership also included senior staff from the private organisation that ran the clinic. This meeting provided oversight of the quality of care delivered by the clinic as well as determining how the clinic worked with the NHS specialist cancer trust. One of the agenda items for the meeting was a quality and safety report for the clinic. The report included mandatory training compliance, incidents, complaints and a review of the clinic risk register.

There was a medical advisory board (MAB) which met every six weeks. Practising privileges to the clinic were granted through this board following submission of information to the chair of the board. We saw in the minutes of one meeting that the granting of practising privileges to a new consultant was discussed and approved by the board members. All consultants had to work at the NHS specialist cancer hospital to be granted practising privileges and were only allowed to work in their NHS area of work. The chair of the MAB was responsible for the revalidation and appraisal of the consultants with practising privileges.

The MAB agenda included compliance with training, quality and safety and any incidents that had occurred at the clinic.

There was a staff meeting for all staff working at the service in Liverpool and on the Wirral. This included all staff, both NHS and non- NHS. Agenda items included medicines safety, audit results, incidents and concerns, staff training and patient feedback. Staff could raise any issues that they had as part of this meeting.

There were daily safety huddles and weekly team meetings to address the day to day issues of the clinics. These were across both clinic sites and were documented.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was a risk register for the service which was part of the risk register for the NHS specialist cancer trust. Managers were able to verbalise the main risks of the service. The risk register was reviewed every month by the Clatterbridge Private Clinic Board. Risks were dated and had mitigating actions attached to them.

There was an extensive audit schedule for the service which included environmental safety, hand hygiene, housekeeping and fire safety. These were carried out every month. There were also ad hoc audits which included administration of specialist anti-cancer treatment, the pre assessment process and phlebotomy. The audit schedule was shared with the staff.

The private service was part of the NHS specialist cancer trust business continuity plans.

Information Management

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

The service was in the process of developing a performance dashboard. A data analyst was seconded to the service to develop a performance dashboard using one of the record systems. This would provide real time data for the service. Currently the information could be obtained manually but this was time consuming.

There was a mortality dashboard to support reviews of patient mortality and to identify any themes and trends.

All staff received training in data protection as part of their mandatory training. Staff were also aware of the Caldicot guardian and their role

The clinic submitted information to the Care Quality Commission as necessary.

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.

The service worked with the NHS specialist cancer trust to promote the services of the clinic with 49% of the profits from the clinic going back into the NHS. The clinic was working on a branding strategy to help to promote the clinic.

The work of the service was included in the induction of the NHS specialist cancer trust staff to the organisation.

The service sponsored the charity ball for the NHS specialist cancer trust and were looking to engage with local sports groups to provide sponsorship. This was to develop engagement with local communities in the area.

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.

The service had a culture of learning and trying to give the best experience to patients that it could. The new registered manager was looking at new ways of working as part of their new role.

Medical care (Including older people's care)

Good

There was participation in research and minutes of the MAB meeting showed that one of the consultants was looking to develop clinical trials through the clinic.

Patients who were co-funded for drugs in development would have any outcomes of their treatment used in the drug trials which if approved contributed to the development of National Institute of Health and Care Excellence guidance