Harley Street at UCH

Quality Report

235 Euston Road
London
NW1 2BU
Tel: (020) 3447 1500
Website: http://www.harleystreetatuch.co.uk

Date of inspection visit: 21 to 23 March 2017
Date of publication: 29/06/2017

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Letter from the Chief Inspector of Hospitals

Harley Street at University College Hospital (HS at UCH) is operated by HCA International Limited. The hospital specialises in adult haematology, haematopoietic stem cell transplant and oncology. There is one inpatient ward on the 15th floor of the host hospital with 31 individual patients' rooms. There is also a dedicated outpatient and day care facility on the 5th floor of the Cancer Centre providing chemotherapy, immunotherapy, supportive care and outpatient services. There is a radiotherapy facility located within the host hospital's radiotherapy department.

The hospital provides medical care and outpatients and diagnostic imaging.

We inspected this service using our comprehensive inspection methodology by carrying out an announced inspection over three days.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

We rated this hospital as outstanding overall. We rated both core services, medicine and outpatient and diagnostic imaging services, as outstanding.

We found outstanding practice in relation to medicine:

- There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe.
- Mortality and infection rates were routinely collected, monitored and reviewed. There was a comprehensive local audit plan.
- Senior leaders actively encouraged openness and transparency.
- There was a sufficient number of staff. Staff were well trained and knowledgeable. They assessed, monitored and managed the risks to people who use services.
- Patients' care and treatment was planned and delivered in line with evidence-based guidance, standards, best practice and legislation.
- Staff were well motivated. They consistently considered peoples' personal, cultural, social and religious needs and delivered kind and compassionate care. We observed that patients' privacy and dignity was maintained at all times.
- The service had been independently reviewed and accredited as meeting internationally recognised quality standards.
- Staff worked together within teams and across services to plan and deliver care and treatment to patients. We observed excellent multidisciplinary team working (MDT) between the nursing, medical and support staff on the unit.
- The service had a highly visible, passionately engaged senior leadership team.

We also found an outstanding practice in relation to outpatient care:

- Without exception, patients told us they were treated with kindness, dignity, respect and compassion.
- Treatment was always consultant led and used evidence based best practice.
- There were reliable systems, processes and practices in place to protect patients from avoidable harm and abuse.
- There was a robust system for capturing and learning from incidents and complaints.
- Senior managers were approachable, visible and listened to staff and patients concerns and ideas. Overall there was a strong sense of teamwork.
- Staffing levels and skill mix met the patients' needs.
- The radiotherapy department were complying with relevant policies, procedures and regulations to protect patients, staff and the public.

Summary of findings

Professor Edward Baker

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Outstanding ☆	Medical care services were a large proportion of hospital activity and we treated medicine as the main core service. Where arrangements were the same within the medicine and outpatient department, we have reported findings in the medicine section. We rated this service as outstanding because it was safe and effective. The service was also very caring, responsive and well led.
Outpatients and diagnostic imaging	Outstanding ☆	Outpatients and diagnostic imaging services consisted of chemotherapy, immunotherapy, supportive care and outpatient services. The main service provided by the location was medicine. Where arrangements were the same, we have reported findings in the medicine section. We rated this service as outstanding because it was safe, effective, caring, responsive, and well led.

Summary of findings

Contents

Outstanding ☆

Harley Street at UCH

Services we looked at

- Medical care
- Outpatients and diagnostic imaging

Summary of this inspection

Background to Harley Street at UCH

Harley Street at UCH is operated by HCA International Limited. The hospital opened in 2006. It is a private hospital in Euston, London. They offer services to adults only.

The hospital has had a registered manager in post since 2015.

The hospital is registered with CQC to offer surgical procedures and treatment of disease, disorder or injury.

Our inspection team

The team that inspected the service comprised a CQC lead inspector Klaudiusz Zembrzuski, other CQC inspectors, specialist advisors with expertise in oncology, pharmacology, palliative care and radiography. The inspection team was overseen by David Harris, Inspection Manager.

An expert by experience was also a member of the inspection team. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer.

Information about Harley Street at UCH

Harley Street at UCH has one inpatient ward located on the 15th floor of the host NHS hospital. The ward is referred to by staff as 'T15' and is a specialist adult haematology, haematopoietic stem cell transplant and oncology facility.

The ward is divided into the North and South wings and provides 31 individual patient rooms each with en-suite bathrooms.

The ward provides complex haematology and oncology treatments, including chemotherapy, stem cell transplant as well as treatment of haematology and oncology emergencies. Palliative and end of life care services are also provided on the ward with a support of an NHS Trust's palliative care team.

The service no longer provided services to children or young people under 18 years old. This had ceased in December 2016 following an internal review.

There is a dedicated outpatient and day care facility on the 5th floor of the Cancer Centre providing chemotherapy, immunotherapy, supportive care and outpatient services. There is also a radiotherapy facility located within the host hospital's radiotherapy department.

The outpatient and day care facility consisted of six outpatient consulting rooms, seven treatment chairs and two single side rooms.

The radiotherapy suite consisted of a treatment planning area, a radiotherapy treatment room and a dedicated waiting area.

Between October 2015 and September 2016 the medicine service treated 322 patients and noted over 711 inpatient attendances (including patients who were admitted more than once). Of these patients, 99% were self or privately funded patients and 1% were NHS patients. Approximately 80% of patients were treated within the haematology department and the majority of the remaining patients were admitted under oncology.

There were a total of 1,729 outpatient appointments at this site between October 2015 and September 2016, including both first and follow-up appointments. All of these appointments were privately funded. There were a further 3,223 day case attendances.

The inpatient care was provided seven days a week. The outpatients department was usually open 8am to 7pm and radiotherapy department from 8am to 5pm, Monday to Friday.

Summary of this inspection

During the inspection we visited both the North and South wings of the ward and spoke with nurses, junior doctors, allied health professionals, interpreters, domestic and catering staff. We also spoke with senior staff including the matron, clinical services manager and clinical director. We also visited the main outpatients, day care unit and radiotherapy department.

We spoke with 17 patients and five relatives and received comment cards from patients who wanted to provide us with feedback.

We spoke with 36 members of staff, including managers, reception and booking staff, nurses of all grades, radiographers and consultants. We observed care on the ward and in a variety of outpatient clinics and in radiotherapy procedures. We also reviewed the systems and management of the departments, including the quality and performance information. In total, we reviewed 19 sets of patient records.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. Staff understood and implemented these processes consistently.
- Staff understood their responsibilities with regards to reporting incidents. There were comprehensive systems in place to review and investigate incidents and learning from incidents was routinely shared with staff. Senior leaders actively encouraged openness and transparency about safety.
- There were comprehensive systems and policies in place for infection prevention and control (IPC). Staff understood their responsibilities with regards to IPC and were actively involved in activity to monitor and review risks. Clinical areas were visibly clean and tidy.
- All medicines were stored safely and appropriately, including controlled drugs (CDs). Pharmacy staff were actively involved in patient journey from admission to discharge and were present at the daily multidisciplinary team meetings.
- Staff were up to date with mandatory training. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately.
- Staff assessed, monitored and managed the risks to people who use services on a day-to-day basis through twice daily safety 'huddles' and effective handovers. Staff recognised and responded appropriately to changes to patient risks.
- The radiotherapy department were complying with all the policies and procedures based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and patient protocols were in place. The IR(ME)R regulations are to protect patients, staff and the public.

However:

- In three sets of paper records we reviewed we found that not all medical notes had been clearly signed by the doctor with their name printed.
- Nursing staff turnover was high.
- Fluid charts were not always fully completed for every patient (in two out four sets of notes we checked for this).

Summary of this inspection

- Policies were not updated within the timescales set by the provider in the radiotherapy department.

Are services effective?

Good

We rated effective as good because:

- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Policies and procedures were regularly reviewed and updated by senior staff. Staff compliance with policies and procedures was monitored using regular audits.
- The service had been independently reviewed and accredited as meeting internationally recognised quality standards for the care and treatment provided. This included joint JACIE accreditation with the host trust for haematopoietic stem cell transplantation.
- We observed excellent multidisciplinary team working (MDT) between the nursing, medical and support staff on the unit. Staff worked together within teams and across services to plan and deliver care and treatment to patients.
- Staff regularly assessed and monitored patients' pain and evaluated the effectiveness of pain medication provided.
- Key performance indicators including mortality and infection rates were routinely collected, monitored and reviewed at a local and national level supporting effective benchmarking and peer review. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff. Information about quality and effectiveness was used to improve care and treatment and people's outcomes.
- There was a comprehensive local audit plan in place which followed the wider organisation's audit plan. Areas for improvement were addressed via detailed action plans and shared with staff. Results were reviewed by senior staff and regular monthly and quarterly governance meetings
- Staff were qualified and had the skills and experience they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training put in place to meet those learning needs. Staff were supported to maintain and further develop their professional skills and experience.

However:

Summary of this inspection

- Outcome monitoring was limited to those patients whose outcomes could be followed-up after they were discharged. Data about mortality was not available for all patients although the service told us about actions they were taking to try and improve this.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- Staff were motivated and inspired to go the "extra mile" to meet patients' individual needs and deliver kind and compassionate care that promoted patients' dignity and independence. We heard about, and saw examples of, individual staff who had had gone above and beyond their job description to provide support and care to patients and their families.
- Patients, and their families, were given appropriate information and support so they understood, and were empowered to make decisions about, the care and treatment options available to them.
- Staff consistently considered peoples' personal, cultural, social and religious needs. We saw additional measures had been introduced to protect female patients' privacy and dignity by respecting their wishes to minimise contact with male staff.
- Patients were overwhelmingly positive about the care delivered by staff. One patient told us, "I feel they are like my family" and another said, "This is a truly outstanding unit, I have never experienced such kindness, care and compassion…the team has made a very difficult time so much more bearable."
- Patient experience survey and family and friend test results showed consistently high scores for the quality of care delivered by staff.
- Patients were provided with emotional, cultural and complementary support services through the dedicated services of the international liaison team. Psychological support and complementary therapies were offered on the ward and patients spoke highly of the positive emotional benefits of these services.

Are services responsive?

Outstanding ☆

We rated responsive as outstanding because:

- The service provided care and treatment in a way that prioritised meeting the needs of individual patients. There was a proactive approach to understanding the needs of different groups of people and to delivering care in a way that met these needs and promoted equality.

Summary of this inspection

- Patients with multiple or complex needs were supported by the service's diverse multidisciplinary team, allowing patients flexibility and choice as well as continuity of care.
- Senior leaders actively welcomed feedback from patients and their families and used this information to improve services. Complaints were managed and responded to appropriately and within the agreed timescales. Managers shared learning from complaints with ward staff.
- An in-house international liaison service was provided to meet the needs of the large demographic of international patients the hospital received. The team were available to provide support 24-hours a day, seven-days a week, from pre-admission to post-discharge.
- Patients had access to multilingual support and complementary therapies services on the ward. This included an Arabic speaking psychologist and a reflexologist.
- Staff consistently demonstrated respect for the cultural and religious views of patients.

Are services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The service's vision, "exceptional people, exceptional care" and supporting values were promoted by the senior leadership team and supported by all staff. Staff understood the vision and values and consistently demonstrated them in their day-to-day work.
- The service had a highly visible, passionately engaged senior leadership team. Staff spoke very highly of senior leaders and said they were approachable and supportive.
- Governance structures were robust and well-embedded within the service and were used to drive and improve the delivery of high quality person-centred care. Escalation processes, lines of accountability, as well as individual roles and responsibilities, were clearly documented and understood by staff.
- Senior staff promoted an open and transparent culture, feedback from patients and staff was actively encouraged and staff felt confident in reporting concerns or near misses.
- Staff were actively supported to develop and career progression and training was encouraged and supported by leaders.
- The service actively reviewed and monitored its working relationship with the host trust. We saw excellent collaboration and multidisciplinary team working.
- Staff were encouraged to take ownership of innovation and felt engaged with the future development of the service.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Outpatients and diagnostic imaging	Good	N/A	Outstanding	Outstanding	Outstanding	Outstanding
Overall	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding

Outstanding ☆

Medical care

Safe	Good ●
Effective	Good ●
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Are medical care services safe?

Good ●

Incidents

- Staff on the inpatient ward were aware of their responsibility to report and record safety incidents and near misses. All staff we spoke with were familiar with the electronic reporting system and how to navigate this. Staff were able to give examples of when they had used the system to report appropriate incidents. Feedback and learning points from incidents were shared with staff across the service via email, newsletters and during daily handovers and safety 'huddles' as well as at monthly team meetings. Nursing staff told us actions that were taken as a result of incidents that had occurred. We reviewed team meeting minutes for December 2016 and saw that incidents and learning were recorded as being discussed. Patient falls were reviewed as a common incident and staff were reminded of the importance of assessing patients for falls risk.
- We saw that incidents and shared learning were discussed and reviewed by senior staff and managers at monthly and quarterly governance meetings.
- There were no 'never events' reported within the service in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Between October 2015 and September 2016, the hospital reported 168 clinical incidents within the inpatient areas. Of these, the hospital reported 98% as 'no harm' or 'low harm'. Only four incidents were classified as 'moderate harm' which included three patients' falls resulting in fractures and one grade 4 pressure sore. The rate of clinical incidents in this reporting period was lower than the rate of other independent acute hospitals. The rate of non-clinical incidents was also lower, with 37 incidents of this type occurring in the same period.
- There was four serious incidents reported by the hospital between October 2015 and August 2016 however the hospital told us they had reported no serious incidents in the six months prior to our inspection. Serious incidents were subject to a root cause analysis (RCA) investigation and action plans were developed where areas for improvement had been identified. We saw three detailed examples of RCAs for incidents that had occurred in 2016, including two patients' falls and a formal complaint about patient care. In each case, senior staff had carried out an investigation and lessons learned had been identified and shared with staff. We saw that a monthly falls audit had been introduced to monitor staff compliance with the requirement to risk assess all patients for falls within 24hrs of admission to the unit.
- Between September 2015 and October 2016, the service reported 40 expected deaths. These deaths were expected and anticipated by the hospital due to the nature of the patient's condition. The hospital reported no unexpected deaths for the 12-month period prior to our inspection.

- The service held monthly morbidity and mortality (M&M) meetings, where all patient deaths were reviewed and discussed in order to identify trends or issues of concern. The clinical director reviewed all patient deaths and wrote a summary letter for the patients' notes. The consultant governance lead then reviewed each case and chaired the M&M meeting. We observed an M&M meeting and saw minutes from three previous meetings from between December 2016 and February 2017. Each patient's history and treatment was reviewed and any complications were discussed. We found that learning points as well as areas of good practice were noted and shared. Any cases where the patient had died within 30 days of receiving chemotherapy received additional scrutiny and the reason for death was reviewed and discussed to identify whether side effects of treatment were a factor.
- Staff at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan. Most staff were aware of their responsibilities with regards to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw an example of a letter of apology to a patient and their family after the patient had developed pressure ulcers whilst on the ward. We were also shown an example where the patient's family had thanked staff for their openness and transparency in dealing with an incident.

Clinical Quality Dashboard or equivalent

- Harley Street at UCH (HS at UCH) was not required to use the NHS Safety Thermometer, as it is an independent healthcare provider. This is a tool which measures harm to patients which may be associated with their care. However, the hospital monitored incidents of patient falls, pressure ulcers, catheter acquired urinary tract infections and venous thromboembolism (VTE) and submitted this information to a central HCA dashboard for monitoring and benchmarking against other sites.
- Although safety thermometer information was not visibly displayed on the ward we saw the 'safety cross', which recorded any patient falls, was displayed on the noticeboard in the sister's office.
- Staff had access to an electronic ward level dashboard which was updated daily with incidents, pressure ulcers and falls. This included a safety calendar function and trend analysis so that staff could see the most common incidents being reported.
- We saw a quarterly management report for quarter four of 2016 which reviewed mortality, patient experience, pressure ulcers, falls and hospital acquired infections amongst other areas. This report presented information on trends and progress against targets and benchmarked HS at UCH's performance against HCA nationally. The number of patient falls, pressure ulcers and medication incidents had all reduced against the previous quarter.

Cleanliness, infection control and hygiene

- The service had comprehensive systems and policies in place for infection prevention and control (IPC). The service followed the host trust's policies on infection prevention and control, hand hygiene and MRSA screening. The service also had its own standard operating procedures (SOPs) which provided more detailed guidance to staff on a number of areas including MRSA swabs and dealing with patients with confirmed or suspected infections.
- The service had reported no incidents of hospital acquired infection MRSA between March 2016 and February 2017. During the same period the service reported three cases of C. Diff and 13 cases of E-coli, both infections associated with healthcare environments. All incidents of infection were reported to the central HCA dashboard and monthly and quarterly reports were reviewed by senior staff to monitor performance against targets. The monthly report for January 2017 showed that all targets were being met with no cases of any hospital acquired infection being reported.
- There was a service level agreement (SLA) with the host trust to provide infection control services to the service, including 24-hour, seven days a week access to a consultant microbiologist and virologist for advice and

support. The SLA also provided access to the host trust's infection control lead nurse seven days a week from 9am to 5pm. The service also had its own SOP providing detailed guidance to staff on how to access IPC support.

- The host trust's infection control (IPC) lead nurse carried out a number of infection prevention and control audits on a monthly basis. These included an 'aseptic and clean touch technique' audit, environment audit and audits of hospital acquired infections. The ward's IPC link nurse worked closely with the host trust's IPC nurse and carried out the monthly hand hygiene audit. Staff we spoke with were aware of who the infection control lead and link nurses were. The link nurse acted as a link between the ward and the trust infection control team. Their role was to increase awareness of infection control issues and motivate staff to improve practice. Staff were aware of who their IPC link nurse was and spoke very highly of her. Staff told us they received regular feedback from the IPC link nurse via email and face-to-face and that she was very proactive in supporting staff and carried out regular informal 'knowledge checks'.
- The trust's IPC lead nurse produced a monthly infection control summary document based on the outcomes of audits on the ward. The host trust's IPC lead nurse met monthly with the matron, ward sisters and IPC link nurse, to discuss IPC issues identified and agree actions to address them. The matron sat on the HCA infection control committee which was responsible for benchmarking IPC across HCA facilities. Staff told us they received feedback about IPC issues and audits via staff meetings, daily huddles and emails as well regular study days. A daily 'safety tracker' tool was used to record and communicate any infection risks during staff handover.
- All staff received annual mandatory training on IPC and at the time of our inspection, 100% of clinical staff had completed this training along with 93% of non-clinical staff. All staff we spoke with were aware of IPC policies and SOPs, including signage on doors for barrier nursing and infection prevention.
- We saw staff were compliant with the hand hygiene policy and cleaned their hands immediately before and after every contact with patients. We saw that staff complied with the 'arms bare below the elbow' requirement of the policy and that hand washing facilities and hand sanitisers were available throughout the ward. The IPC link nurse audited staff compliance with the hand hygiene policy monthly. We saw results for the six months August 2016 to February 2017 were generally good but varied between 85% and 100%. Senior nursing staff discussed areas for improvement at the monthly IPC meeting and recorded actions on the IPC action plan. Staff told us they received regular feedback and reminders from their IPC link nurse.
- Protective precautions signs were placed on the door to a patient's room either when a patient was infectious or at increased risk of infection. These signs reminded staff to wear appropriate personal protective equipment (PPE) and to clean their hands before and after contact with a patient. All staff we spoke with, including the domestic assistants and patient support workers, were able to tell us what the signs meant and how they would adhere to the precautions. We saw that appropriate PPE including aprons and gloves were readily available at the entrance to all patients' rooms. All staff we saw entering patients' rooms followed the correct procedure.
- There was a SOP in place for isolating patients with infections. Two patients had been moved to the trust isolation ward at the time of our inspection and a third patient was in isolation on the ward. We were told that no transmission of infection had been reported on the ward. The trust microbiologist visited the ward twice a week with the virologist to support ward with infection control monitoring. They told us that staff responded very quickly to feedback and that issues were addressed promptly.
- Cleaning services on the ward were provided via a SLA with the host trust. We saw that a detailed cleaning schedule was displayed in the ward's reception area. Cleaning checks were carried out daily by the domestic supervisor who also attended the weekly environment review carried out by the trust's environmental monitoring officer and IPC lead nurse. We reviewed the notes of one environment review carried out on 7 March 2017 and saw that all issues, such as high level dust or fridge requiring cleaning, were assigned to responsible person and given a completion date.
- We found that the ward, and all clinical areas we inspected, were visibly very clean and tidy and all

equipment we checked had been recently cleaned and labelled as ready for use. All waste including chemotherapy waste and sharp objects were disposed of correctly in line with national guidance.

- Once a room had been cleaned and prepared for the next patient, a protective 'seal' was placed across the door which warned staff and visitors not to enter as the room had been 'hygienically prepared to meet our high infection control standards and sealed for patient admission'. This was signed and dated to show when it was cleaned. We inspected one of these rooms and found that it was visibly clean and all equipment was ready for use.
- Patient support workers were always available on the ward and part of their responsibilities included cleaning equipment and labelling as clean and ready for use. Staff used green 'I am clean stickers' to indicate that equipment had been cleaned and was ready for use – we checked 11 items of equipment which were labelled as clean, including three commodes, and all were clean and ready for use.
- Patients we spoke with told us they were very happy with the cleanliness of their rooms and that staff always washed their hands. Patients told us "everybody washes their hands", "very high level of cleanliness" and "(staff) clean their hands conscientiously".

Environment and equipment

- The ward consisted of 31 en suite private patient rooms. The unit was physically divided into two wards with 13 rooms on T15 North and 18 on T15 South. Each ward had its own clinical treatment room, dirty utility room and nurses' station.
- The ward was located in the NHS hospital and there were service level agreements in place in relation to facilities management. All of the equipment we looked at on the ward was owned and managed by HS at UCH.
- We saw that resuscitation equipment was stored securely in designated trolleys on each ward. We checked each trolley and saw that all emergency medicines and consumables were fully stocked and in date. Emergency equipment was clean and ready for use. Staff were trained in its use as part of their mandatory life support training. We saw that staff recorded daily equipment checks.
- Sharps bins were appropriately assembled, labelled and not overfilled.
- We checked 11 items of equipment on the ward and found that all items had been recently safety tested and cleaned.
- Staff told us they had been suitably trained to use the equipment on the ward and knew how to escalate any issues or faults.
- A central HCA team, responsible for more than one location managed by the provider, serviced and maintained the majority of equipment on the ward. Feedback from staff was that this system worked well and the team were very responsive once contacted. Staff took personal pride in maintaining a safe environment for example a physiotherapist had introduced a system for monitoring servicing of all lifting equipment such as hoists.
- The host trust's environmental monitoring officer completed a weekly environment review 'walk around' of the ward. The facilities manager and the host trust's IPC lead nurse also attended this review. Where necessary we saw issues were escalated to the host trust's estate team.
- A monthly environment and equipment audit was carried out which included a general review of the appearance of clinical areas and equipment storage as well as looking specifically at IPC issues such as PPE and isolation procedures. We reviewed two completed audit documents for January and February 2017. Issues highlighted included flooring needing repair and equipment requiring PAT testing. All issues had an action assigned to a person and a deadline for complication as well as a status update showing whether the action was completed, in progress, had been deferred, escalated or not started. All actions we saw were either completed or in progress.

Medicines

- There was a ward-based pharmacy staffed by a pharmacy team including a qualified haematology pharmacist. There was a pharmacy service provided to the ward Monday to Friday, between 9am and 5.30pm. Outside of these times, and at weekends, a qualified pharmacist and pharmacy technician were

- All medicines were stored safely and appropriately, including controlled drugs (CDs). Medicine keys were kept separately and locked in electronically locked storage units which could only be accessed via a pin code. Suitable emergency medicines, extravasation and spill kits were available and checked regularly.
- Chemotherapy medicines were provided under an SLA with another local HCA hospital and prepared off-site. The SLA was monitored and delays, if there was any, were recorded and investigated
- We inspected the treatment room and found that all drugs cupboards, including the drugs fridge, were locked and there was a separate cupboard for cytotoxic drugs used for chemotherapy treatment. Safe procedures for drugs for intrathecal administration were followed, including separate storage, training and the maintenance of a register of practitioners.
- Staff monitored medicine fridge temperatures daily and a new system had just been introduced to improve the safety of the process. The temperatures in one clinic room had recently been recorded as above safe limits, so a temporary storage room was in use whilst arrangements were made to improve the facilities. This was recorded on the risk register for the unit and the issue was being monitored and reviewed regularly, including daily room temperature checks.
- The pharmacy had recently increased its auditing of controlled drugs to improve compliance with recording. Non-compliance in several areas was picked up during the quarterly audits in 2016 including expiry dates not being checked and daily balance checks not being recorded correctly. Additional daily checks and monthly audits had been introduced to monitor compliance with agreed actions.
- Medicines reconciliation was carried out by pharmacists on all patients, it is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, or GP. The service's target for compliance was that 70% of patients should have had their medicines reconciled within 24 hours and 100% within 72 hours. A quarterly audit was carried out to measure compliance. We reviewed the audit results for April and July 2016 and found both these targets were met, with 100% of reconciliations completed within 48hrs in both audits.
- The senior pharmacy technician carried out a quarterly treatment room audit. Areas of non-compliance were discussed with the pharmacy operational manager and actions were agreed with the senior nursing team to improve compliance. Audit outcomes were discussed at nursing and pharmacy departmental meetings and local governance meetings.
- We reviewed audit reports for October 2016, December 2016 and January 2017. Several issues were identified across the unit including fridge and room temperature not being recorded daily, drugs stored for patients who had been discharged and inappropriate storage of IV fluids. Compliance varied from 85% to 54% over the period. A detailed action plan was in place to address these issues. More frequent audits were planned to confirm compliance with the action plan. During the inspection, we did not see any of the issues highlighted by the audit. Fridge and room temperatures in ward treatment rooms were all checked daily in line with hospital guidelines, drugs and IV fluids were kept in locked cupboards.
- We reviewed 10 prescription charts during the course of the inspection. Patient allergies were clearly recorded on each chart and all prescriptions were signed and dated. The service followed the host trust's policy for antimicrobial prescribing and management and one of requirements of this policy was documentation of a stop or review date.
- We found that three out of 10 records we reviewed had antibiotic prescriptions without review dates. However, we saw that where review dates were not recorded the correct action had been taken. A quarterly audit of compliance with antimicrobial policy for March 2017 showed 86% compliance against this standard, an improvement from 60% compliance in January 2017. A pharmacist had been assigned to the microbiology rounds to support compliance with the antimicrobial policy and antimicrobial prescriptions were reviewed daily.
- Senior staff told us about an incident in January 2017 where a member of staff gave a patient an

anti-coagulant rather than anti-viral medication. A nurse had accessed the pharmacy out of hours and accidently used the wrong medication. Staff had not followed correct procedures for accessing pharmacy out of hours. In response to this the local service operational procedure (SOP) for accessing pharmacy out of hours had been reviewed and updated. We reviewed procedures for access to the pharmacy out of hours and found signing procedures required a doctor to gain access. Senior staff told us additional training on drugs administration had been delivered to staff and checks were in place to prevent future errors occurring.

Records

- Staff used both electronic and paper-based records to record patients' care plans, medical decisions, reviews and risk assessments. Managers told us that plans were being discussed to eventually keep all records electronically.
- Staff kept paper records securely in locked trollies, which could only be accessed via a pin code. We checked two trollies and found them to be locked. Staff completed information security training annually as part of their mandatory training.
- We reviewed 10 sets of notes on the ward. We found that all risks assessments were completed for falls, venous thromboembolism (VTE), pressure ulcers, nutrition and mobility. National early warning system (NEWS) charts were completed appropriately and patients' pain was assessed and documented. Nursing documentation was well completed and recorded all actions taken and how patients' needs were being met. However, in three sets of paper records we reviewed we found that not all medical notes had been clearly signed by the doctor with their name printed.
- We found that fluid charts were not always fully completed (in two out four sets of notes we checked).
- Nursing staff carried out a record keeping audit twice a year to measure compliance against professional standards. Audits for August 2016 and February 2017 indicated compliance was generally good at 97% . However, improvement highlighted by the earlier audit were still not fully complied with six months later. This included admission and clinical risk assessments not completed within 24hours of admission and patient`s response to medication not being documented. A detailed action plan was in place to address areas of non-compliance but there were no plans to re-audit more frequently.
- Medical records officers were responsible for carrying out monthly medical records audits to measure compliance with best practice guidelines on the structure and content of health records issued by professional regulatory bodies. We reviewed the audits for December 2016 and February 2017, which reviewed a sample of 20 paper medical records. Although compliance had increased from 65% to 75% there were ongoing issues with missing documentation.
- Results of the six-monthly medical records audit were discussed in the medical advisory committee (MAC) meeting and actions were recorded to encourage compliance. The audit had been introduced following an investigation and subsequent inquest into an unexpected patient death on the unit in July 2015. It was identified that on occasion the doctor reviewing the patient had not made an entry in the patient's medical notes. The audit for November 2016 showed a positive upward trend in the percentage of patient notes having entries made every day by medical staff over a seven day period. The average compliance percentage for the nine months for which data had been collected was 78%, which compared favourably to the original December 2015 baseline of 47%. We noted that staff achieved 100% compliance in two of the audited months.

Safeguarding

- All staff completed safeguarding adults and children levels 1 and 2 as part of their annual mandatory training. At the time of our inspection, 100% of staff had completed this training.
- Staff knew when and how to escalate a safeguarding concern and gave examples of this. We spoke to several members of staff and all were able to tell us about a recent safeguarding case which had taken place on the outpatient's unit.
- The chief operating officer (COO) was the designated safeguarding lead for both adults and children and was trained to level 4 for both. Day-to-day this responsibility was delegated to the clinical service manager (CSM)

who was trained to level 3 for both. The CSM was responsible for recording and monitoring safeguarding alerts and escalating to clinical governance meetings and MAC meetings for discussion.

- The matron had level 3 adults safeguarding training and level 4 children's safeguarding and had also completed supervisors' course for children's safeguarding.
- The service used the host trust's safeguarding policy and had a HCA standard operating procedure (SOP). The SOP provided detailed guidance for staff on how to raise a concern if they believed or suspected an adult was at risk of abuse or neglect whilst receiving care on either the inpatient or the outpatient unit.
- The safeguarding policy and escalation flow-chart were clearly displayed for staff in the treatment rooms on both wards. Staff reported safeguarding alerts via the electronic incident reporting system and escalated to the host hospital's safeguarding lead as well as the hospital's social work department.

Mandatory training

- Mandatory training included basic life support, fire safety, safeguarding adults and children levels 1and 2, infection control, health and safety, manual handling and information security. Average compliance for nursing staff was 98% in all training modules. All staff had completed safeguarding adults levels 1 and 2, equality and diversity, manual handling theory and ethics.
- All new starters completed their initial mandatory training during their induction week. Training was available to staff through a combination of face-to-face training and e-learning modules. All staff we spoke to felt they had sufficient opportunities to access mandatory training
- The unit had a full time clinical practice facilitator (CPF) who was responsible for monitoring training compliance and training new starters. The online learning system would automatically generate an email reminder for staff when training was due and that the CPF would send a further email reminder if required.

Assessing and responding to patient risk

- Harley Street at UCH (HS at UCH) had a service level agreement (SLA) the host trust to provide junior doctor cover to the inpatient unit. This had included a junior doctor post as well two full-time haematology specialist registrars to work Monday to Friday from 9am to 5pm. However, we were told that the junior doctor post had recently been removed by the trust. In response, the service had taken on a full-time resident consultant to provide expert support to junior doctors on the unit. Out of hours junior doctor cover was provided under an SLA with the host trust. Two specialist registrars, one specialising in oncology and the other haematology, and one HCA RMO doctor were available between 5pm and 8am, Monday to Friday and at all times at the weekend.
- The hospital used the national early warning score (NEWS) to identify deteriorating patients. This is a basic set of observations such as blood pressure, respiratory rate, oxygen saturation, temperature and pulse rate.
- Staff took observations and calculated each patient's NEWS scores at least four times within a 24-hour period and more frequently if required. We observed the NEWS score for each patient being reviewed and discussed at the twice-daily nursing handover. The chart used to record the score had set parameters for each observation and clear instructions as to what action staff should take based on the patient's score. A NEWS score of five or above required staff to immediately inform the ward's resident medical officer (RMO) and escalate the patient to the trust's outreach team.
- The monthly audit of NEWS for February 2017 showed 100% compliance in recording NEWS essential vital signs and adhering to the required actions in response to NEWS score.
- We reviewed 10 sets of patient records and found that in all cases the NEWS scores had been recorded and correctly calculated and appropriate action had been taken when required.
- The service had an SLA with the host trust to provide an emergency outreach service this was provided by the patient emergency response and resuscitation team (PERRT). Staff told us the SLA worked well and the PERRT could always be contacted if needed.
- All staff completed basic life support training as part of their mandatory training. The clinical practice facilitator

told us that the majority of clinical staff had also completed intermediate life support training within the previous 12 months. The RMOs had all completed advanced life support training.

- Monthly audits were carried out by nursing staff on the ward to review compliance with controls put in place to reduce the risk of patients falling or acquiring pressure ulcers. Controls included comprehensive risk assessments and training for staff to ensure compliance with organisational policies.
- NICE recommends that all patients should be assessed for risk of developing thrombosis (blood clots) on a regular basis. Between September 2015 and October 2016, screening rates for venous thromboembolism (VTE) were above 95% and there were no reported incidents of hospital acquired VTE or pulmonary embolism (PE). Risk assessments were appropriately completed in the records we reviewed.
- All patients were assessed for falls risk on admission, we were told this this should be completed within the first 24 hours after admission to the unit. In December 2016, the service carried out a random audit of 21 patients' records from the previous 12 months. Out of 21, four did not have their risk assessment completed within 24hrs. Where any risk had been identified, appropriate measures had been put in place such as one to one nursing assistance or mobility aides. A detailed action plan was in place to address areas for improvement and to share learning with staff. A 'falls champion' role had been established on the ward to provide additional support to staff and further monthly audits were planned.
- We reviewed a sample of 10 patient records and found that all contained completed risk assessments for falls, pressure ulcers and VTE. We saw that the 'Call, don't fall' safety message was clearly displayed, in both English and Arabic, in patient rooms and as well as toilets on the ward.
- We saw that a 'safety tracker' document was used to communicate any ward risks between staff. This document was comprehensive and included patient numbers and acuity, any staff absences and bank or agency staff, details of patients at risk of falls, pressure sores, any infections and any incidents or faulty equipment.

Nursing staffing

- We found that staffing levels on the wards were sufficient to keep patients safe, and met or exceeded recommended national guidelines (NICE SG1: Safe staffing for nursing in adult inpatient wards in acute hospitals). Staff to patient ratios were usually 1:3 during the day and 1:4 at night but these could be flexed to meet patient needs. The senior sister used a staffing tool to plan staffing and kept it updated to accommodate changes in patient numbers and acuity. The ward manager or junior sister was responsible for allocating patients to nurses at morning handover, once acuity had been discussed and staff skills reviewed.
- The ward was managed by the matron who was also responsible for managing the separate outpatients unit. Day to day management of the wards was delegated to a senior sister and ward manager. A 'manager on duty' system operated to ensure that there was always a member of the team who was supernumerary. This was usually the senior sister, ward manager or a junior sister at nights and weekends.
- Nursing handovers took place twice daily at 8am and 8pm. Separate handovers were held simultaneously on T15 North and South wards. Twice daily safety 'huddles' were used to communicate important safety information within the wider multidisciplinary team (MDT). These sessions were used to identify any updates required to staffing in real time. Information on acuity and dependency of patients, as well as any admissions and discharges was used to adjust staffing levels accordingly ensuring there was always an appropriately trained nurse looking after patients and a safe nurse to patient ratio. Staffing ratios could be flexed to provide 1:1 or 1:2 care depending on patient acuity and clinical need.
- We observed two nursing handovers taking place and found that relevant information was handed over and that all staff were actively engaged in the handover process. We saw that bank and agency nurses were actively involved in the handover process and were very knowledgeable about their patients. NEWs scores and any risks and actions were shared and discussed.
- The service had four full-time clinical nurse specialists (CNSs) for haematology, oncology, myeloma and

lymphoma. A further CNS was due to start in May 2017. In addition there were four CNSs provided under a SLA with the host trust for infection control, sarcoma and transplant.

- There were four junior sisters and 16 staff nurses in post and six vacancies. Three additional nurses had been successfully recruited and were due to start shortly. The senior sister was also due to carry out interviews the week after we inspected to appoint staff to the remaining vacancies.
- Senior staff said the service had experienced difficulties with recruiting and retaining specialist haematology nursing staff. Nursing staff turnover was high at 27.8% during the period September 2015 to October 2016. This issue had been recorded on the service's risk register and we were told that actions were ongoing to improve retention including offering a bonus to staff that had completed six months in post.
- Agency and bank staff usage rates had previously been higher than average when compared against similar services however, this showed a consistent downward trend over the period October 2015 to September 2016, reducing from 38% to 11%. Senior managers told us it was due to improved recruitment and retention of permanent staff.
- Permanent staff spoke very highly of bank and agency staff and the majority of temporary staff worked on the unit regularly and were therefore very familiar to staff and patients. Staff said that agency and bank staff were treated as "part of the team". Agency staff we spoke with confirmed this and told us they were well supported by their permanent colleagues.
- Senior nursing staff said there were never any issues requesting bank or agency staff and there were never any unfilled shifts.
- Staff could be moved to work on either ward but the ward manager told us that they would usually allocate to the same side for several shifts to allow for continuity of care. Staff told us this system worked well and they were happy to move between the two wards within the unit as they worked as one big team.
- There were no health care assistants employed to work on the ward however, there was always a patient support worker on duty. Their role included topping up stock, cleaning equipment and making beds.

Medical staffing

- All patients were admitted to the unit under the care of a named consultant. The consultant reviewed the patient on admission and could be contacted out of hours if required. Consultants held their ward rounds usually twice or three times a week and were accompanied by the ward's resident consultant.
- The majority of consultants were employed by the host trust and worked on the unit under a practicing privileges arrangement. There was one directly employed ward-based consultant on the unit. This was a resident consultant in haematology who had joined the service in January 2017 and worked Monday to Friday 9am to 5pm.
- There was a documented escalation and referral process, which all staff were aware of, with the junior doctors required to report to the specialist registrars and they would escalate to a consultant if required. If a specialist opinion was required the junior doctor or patient's own consultant would contact a consultant of the relevant speciality who had practicing privileges with HCA. A consultant directory was available in all clinical areas for consultants who had practicing privileges. In an emergency situation if the consultant specialist was unavailable, the junior doctor would contact the relevant trust on-call consultant.
- There was a resident medical officer (RMO) present on the ward at all times. They were responsible for reviewing patients on a daily basis and communicating with the patients' lead consultant. There were two HCA employed RMOs, one for the inpatient ward and one for the outpatients unit, who both worked Monday to Friday 9am to 5pm, they did not work on call or out of hours. There were two RMOs on shift during the day, one early and one late shift this ensured that there was also an RMO providing cover during breaks.
- We found that medical handovers were effective at communicating all relevant patient information. Junior doctors told us that they felt that handovers worked well and that they felt well supported by their senior colleagues. We observed a morning handover take

place between the night RMO and the junior doctor coming on to shift. We saw that there was a detailed discussion about a new patient's diagnosis, investigation and treatment plan.

- RMOs working at night said they felt very well supported by consultants and were able to contact them for advice via telephone. They had access to support from the host trust's on-call haematology or oncology speciality registrar (SpR).
- RMOs told us they were invited to governance meetings and felt very well supported by their more senior medical colleagues. We were told that there were lots of opportunities for training and development and that they were encouraged and supported to attend if they so wished.
- Feedback from nursing staff confirmed they felt well supported by medical staff and would not hesitate to ring a consultant directly. Out of hours if a patient deteriorated, staff would contact the host trust's on-call haematology or oncology speciality registrar and then email or text patient's own consultant to make them aware.

Emergency awareness and training

- The service referred to the host trust's policies and procedures for major incident management and emergency preparedness, resilience and response.
- Information was kept on the ward informing staff of what to do if an incident occurred on the ward and in the event of a major emergency.
- The matron and clinical services manager told us that the business continuity plans were reviewed annually and that they worked closely with the host trust on major emergency and incidents planning. We heard that the matron had recently taken part in a training exercise run by the host trust to test emergency response and management procedures.
- We saw minutes from the most recent quarterly clinical governance meeting held in February 2017 in which emergency response procedures were reviewed and feedback from the host trust was discussed.

Are medical care services effective?

Good

Evidence-based care and treatment

- The service was independently reviewed and accredited as meeting internationally recognised quality standards for the care and treatment provided to patients. This included joint JACIE accreditation with the host trust for haematopoietic stem cell transplantation (Joint Accreditation Committee of the International society for cellular therapy [ISCT] with the European Society for Bone Marrow Transplantation).
- The service had also gained accreditation from caspe healthcare knowledge systems (CHKS) demonstrating they met the high standards of quality required. CHKS is a quality assurance programme with a framework of standards that are externally audited on an annual basis and includes ISO 9001 accreditation.
- Staff provided care and treatment according to both HCA and the host trust's policies. Policies we reviewed met the national best practice guidance of recognised organisations including the National Institute for Health and Care Excellence (NICE). The medical advisory committee and clinical governance committee maintained a database of all policies. New NICE guidance and actions relevant to the service were reviewed monthly at clinical governance meetings to support the implementation of evidence-based practice.
- National Early Warning Score system (NEWS) was used to identify deteriorating patients in line with National Institute for Health and Care Excellence (NICE) guidance CG50 'Acutely ill-patients in Hospital' using the host trust's policy 'Recording Vital Sign Observations & Reporting Abnormalities'.
- All policies we reviewed had a document owner, a date of approval and a date for review. All were within their review date. Trust policies covered a wide range of areas including safeguarding, resuscitation and infection prevention and control (IPC). Where the service had a service level agreement (SLA) to provide services such as IPC and the emergency outreach team, we saw there were standard operating procedures (SOPs) in place

giving staff more detailed guidance on how to access services and comply with the trust policies. Staff we spoke with knew how to access these policies and local procedures via the intranet.

- The service had a comprehensive local audit plan covering vast range of areas including infection control, resuscitation, medical records, and pharmacy. We reviewed a number of audits including those for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR), national early warning system (NEWS), hand hygiene, pain, falls, controlled drugs and environment. We found that the audits effectively assessed staff compliance with HCA and trust policies and detailed action plans were in place to address areas for improvement. We saw evidence that audit results were shared locally with staff as well as discussed and reviewed at monthly and quarterly governance meetings.
- The service carried out performance benchmarking against other HCA hospitals. Key measures of performance including mortality and patient experience were submitted to a central HCA dashboard and used to benchmark the service against other HCA facilities. Senior staff reviewed performance in monthly operational meetings and clinical governance meetings. Staff discussed results and actions at monthly team meetings.
- Staff followed the host trust's policy for assessing and managing patients with suspected neutropenic sepsis. Neutropenic sepsis is a potentially fatal complication of cancer treatment caused by a suppression of the patient's immune system. NICE guidelines state it is critical to ensure antibiotics are given immediately to those with suspected neutropenic sepsis. Senior nursing staff carried out a quarterly audit to ensure patients with suspected neutropenic sepsis were appropriate managed. Results from the February 2017 audit confirmed 100% compliance and, in all suspected cases, patients were given intravenous antibiotics within one hour.
- Staff had access to a HCA corporate policy (Corporate Care of the Dying Adult in the Last Days of Life Guideline) for managing patients nearing end of life. The purpose of the document was to support staff in ensuring all patients and relatives receive appropriate, compassionate individualised care. The document was based on NICE guidance (NICE Guidelines [NG31] Care of dying adults in the last days of life. December 2015) and on the five priorities of care from the Department of Health's 2014 document 'One Chance To Get It Right'. The guidance covered symptom management, nutrition and hydration as well as communication and decision-making and providing individualised care by discussing each patient's needs and preferences.

Pain relief

- Staff used a recognised tool based on a numeric rating scale to assess patients' pain and the effectiveness of pain relief. Staff told us if a patient's pain score went up then they were reviewed by a doctor and given pain-medication. Nurses would then monitor and assess each patient's response to the medication and record this in the nursing notes.
- We reviewed 10 sets of patient notes and found that staff had regularly assessed and recorded each patient's pain.
- We observed that patients' pain levels were discussed at the nursing handover and there was a discussion as to whether to refer to palliative care for symptom management.
- The senior sister carried out a quarterly pain audit to assess staff compliance with HCA best practice recommendations for pain management. The audit checked patients' records to confirm that an initial pain assessment on admission had been received, that regular pain scoring had been documented and that pain relief was offered when appropriate. It also assessed whether the patient had been seen by a doctor if they had been reporting moderate pain for four hours or more. Results for November 2016 and February 2017 showed 100% compliance.
- A pain link nurse on the ward provided guidance and support to ward staff.
- All patients we spoke with told us their pain was well managed and that staff responded quickly to call bells. Patients said that pain relief was checked for effectiveness and they were asked regularly about whether they were in any pain. One patient said, "It is challenging when I am in pain at night and need something new" (when a doctor is needed to prescribe a new type of pain medication) and commented that this situation was generally managed well by staff, stating,

"Staff are very attentive". One patient told us, "They [staff] deal with it [pain] quickly", and another said "I can ask any of the staff when I am in pain for pain relief." A further patient told us, "They treat me well for my pain" and "even when I am not in pain they always ask me".

- The patient experience survey results for 2016 asked patients how well staff did everything they could to control their pain and 100% said 'Excellent, Very good or Good'.

Nutrition and hydration

- The ward-based dietitian assessed all new patients for malnutrition on admission. All records we reviewed had evidence of dietitian input and discussions with patients and relatives about nutrition and diet were documented in their notes. However, not all fluid charts were fully completed; two out of four records we reviewed did not have fully completed fluid charts.
- Staff used a five-step malnutrition universal screening tool (MUST) to identify adults who were malnourished or at risk of malnutrition. This involved weighing the patient regularly to monitor any weight changes and then allocating a score based on risk. In all 10 patient records we reviewed patient nutrition had been risk assessed and weight monitored. The dietitian told us she was responsible for the monthly MUST audit and had worked to improve staff completion compliance.
- The dietitian was available on the ward Monday to Friday 9am to 5pm and out of hours, support was available for ward staff via the nutrition resource folder and policy library. Staff had an out of hours processes which they could follow if they had a patient who was unable to eat food normally and required a nasogastric tube or other nutritional support. There was also nutrition link nurse on the ward who worked with the dietitian to support staff. We saw that the dietitian attended the twice-daily safety huddles and was available to offer advice and support to staff on the ward.
- The dietitian provided all patients on a special neutropenic diet with information about what they could and could not eat. Patients who are neutropenic have an abnormally low concentration of neutrophils (a type of white blood cell), reducing their immune system's ability to fight infection. This can be caused either by the patient's medical condition itself or as a side effect of cancer treatment. We saw during the nursing handover that patients identified as neutropenic were clearly highlighted on the patient details board and referral was made to the dietitian. The dietitian told us the menu had been designed to meet the needs of neutropenic patients and that any unsuitable options were obviously labelled.

Patient outcomes

- All patient care was consultant led and patient outcomes following discharge were followed up by the CNSs. One of the haematology consultants held a clinic in Kuwait were they reviewed patients once they had been discharged.
- Senior staff attended monthly and quarterly clinical operation review meetings where clinical key performance measures, incidents, staffing and patient satisfaction were discussed and actions agreed. Patient mortality, transfers and readmissions were subject to trend analysis and patient experience was benchmarked against HCA average. We saw the quarterly report for October to December 2016 which showed the service consistently performed better than average for patient satisfaction scores. However, compliance with reporting MDT outcomes on the electronic record system was significantly below target at 32.79% against 100% which indicated that not all patient information was being correctly recorded. The service told us that this was not a true reflection of their compliance in recording patient MDT outcomes as outcomes were reported across several electronic record systems. We were told that staff had access to all relevant MDT outcomes for each patient".
- The service audited patient outcomes for all patients treated with chemotherapy on the ward for acute myeloid leukaemia (AML), a type of blood cancer. Remission and mortality rates for all patients treated in 2015 and 2016 were benchmarked against national clinical trials. Mortality rates were similar to patients entered on the UK clinical trials for AML. Average remission rates for patients treated at the service appeared slightly lower than the average for patients on UK clinical trials. However, over half the patients treated on the ward by the service had high risk disease whereas the clinical trials had very strict

exclusion criteria, which may excluded high risk patients. This made it difficult to directly compare the outcomes due to the differences in clinical acuity of the two patient groups.

- For standard chemotherapy treatment the average remission rates for patients treated for AML on the ward were 80% against an 84% average for national trials patients. For chemotherapy treatment for high risk AML patients average remission rates on the ward was 56% which was slightly worse than the 63% average remission rate for patients in national trials. We were told that the service was unable to benchmark against any other HCA sites as they were the only site treating this case mix of patients and aside for the national trials for AML it was difficult to benchmark against the NHS.
- The service had plans to recruit a haematology data manager in 2017 so that outcome data could be collected for all tumour types and a database had been built to collect this data. Future audits were planned to measure outcomes.
- The service collected and reviewed outcome data for all patients receiving bone barrow transplants. Outcome data underwent both national and international benchmarking against patients receiving transplants at other hospitals both within the UK and across Europe. Mortality and survival rates for all patients who received stem cell transplant were reviewed annually. All bone marrow transplant (BMT) data was submitted to the British Society of BMT and European BMT (BSBMT) as a joint centre with the host trust's NHS service.
- The annual BSBMT benchmarking report indicated the service compared favourably to national outcomes for the whole of the UK. However, the report did not differentiate NHS from private patients as data was submitted jointly and the same BMT and BSBMT guidelines for transplant were used for all patients.
- The service, in conjunction with the host trust, held an annual mortality assessment of all patients who had received haemopoietic stem cell transplantation (HSCT). This mortality review included NHS patients who had received treatment through the host trust, as the programme was run jointly. Transplant-related causes of mortality (TRM) were assessed at 100 days and at one year post-transplant. Death from recurrent/progressive disease was also monitored. The 100 day TRM was investigated for all recipients of HSCT whose 100 day post-transplant time-point occurred between September 2015 and September 2016.
- TRM was within expected rates both at 100 days and one year. An annual assessment of overall survival was also calculated for all eligible patients whose one year post-transplant time point fell within the 12 month period above. Overall survival at 12 months post-transplant was 90% of all autologous recipients and 74% of allogeneic recipients. Which was within the expected range.
- The service carried out a separate internal mortality review of all patients who underwent transplantation at HS at UCH. A total of 240 transplants performed between January 2007 and September 2016 were reviewed and found overall survivorship was 70%. Outcomes were found to be broadly comparable to those outcomes of the wider transplant service (which included NHS patients). Limitations of this review were noted as 23% patients were 'lost to follow up' and therefore outcome data was not available for them once they were discharged from the care of the service. in some cases this was due to international patients returning home to overseas once discharged from the hospital. We were told that the BMT data manager actively pursued follow up data on all BMT patients and efforts were being made to try and improve outcome data availability.
- Staff at all levels were actively encouraged to get involved in reviewing patient outcomes. Two clinical nurse specialists (CNSs) had been supported to attend an International Myeloma Conference in India in March 2017 to present on the impact of a chemotherapy drug on patients with multiple myeloma and amyloidosis. This drug had not yet been assessed for NHS funding in the UK and outcome data was needed to assess the effectiveness. Data was presented from a review of 28 patients who had received the drug at HS at UCH. Treatment side effects, requirement for overnight stay and patient feedback was considered. The CNS team had shared learning with staff on the wards via a summary presentation at a recent staff education day.

Competent staff

- All nursing staff had completed an annual appraisal with their line manager.
- All new nursing staff had completed a comprehensive two-week induction programme followed by a two-week supernumerary period. This allowed them to complete all required mandatory training and to consolidate their learning.
- We saw training materials used to train every new starter. All completed training modules were uploaded to the online training record system.
- New starters were on a three-month probationary period during which their performance was regularly reviewed by the clinical practice facilitator (CPF) and their manager. The CPF told us they had recently introduced 'wellbeing' checks with new starters to follow up on their progress within their first few months. Staff spoke very positively about the CPF and told us they felt well supported in completing their training.
- All new nurses received on-site training in chemotherapy which was achieved through completion of two workbooks. The ward manager told us that staffing rotas were planned to ensure that there were always nurses trained to give chemotherapy on each shift and that bank nurses were trained to give chemotherapy.
- We were told that all nursing staff (including those regular bank and agency staff) were trained to use syringe drivers and that these were kept on the ward in case they were needed. Syringe drivers were used to deliver pain relief to patients approaching the end of life. The palliative care team was also available to support staff with this.
- The medical advisory committee (MAC) and clinical director reviewed practising privileges for consultants annually. All new consultants requesting practising privileges were required to complete an application and supply evidence of revalidation before being considered by the chief executive officer (CEO) and then the MAC. Consultant credentials were reviewed monthly via a report provided to the CEO through the centralised credentialing and registration service based within the HCA corporate office. Any concerns, including competencies, raised about consultants were dealt with through the 'Responding to Concerns' policy via a local decision making group (DMG) and then the Corporate DMG if required.
- Junior doctors on the ward were employed directly by the service completed both HCA and trust inductions and mandatory training. The clinical service manager (CSM) was responsible for monitoring junior doctor training. Junior doctors we spoke with told us they felt well supported and had access to training opportunities. A consultant told us junior doctors were "well informed and capable" and "communicate very well", they also said that there were high levels consultant input.

Multidisciplinary working

- We observed excellent multidisciplinary team working (MDT) between the nursing, medical and support staff on the unit. There was a twice-daily MDT 'safety huddle', which included RMOs, pharmacist, physiotherapist, interpreters, dietitian, admin staff as well as nursing staff and the resident consultant. We attended one 'huddle' and saw that all staff were encouraged to contribute to the discussion. Junior staff told us they felt able to raise any concerns and said that they were supported to do so. We saw that the team discussed whether they felt patient's pain was being managed well and considered referral to the palliative care team. Staff discussed patient risks and individual needs and input requested from appropriate support services, including palliative care and tissue viability teams.
- We observed a ward round which the resident consultant, the haematology specialist registrar and the junior doctor (RMO) attended as well as the interpreter. We saw that the consultant was knowledgeable and approachable and encouraged input from the junior team members. We noted that there was no nursing representation at the ward round however nursing input was gained via the twice-daily 'huddles'. The interpreter was helpful in facilitating discussions with Arabic patients and their families.
- The service held a weekly haematology MDT meeting to review all haematology patients. We saw excellent team working and collaboration demonstrated by attendees. The consultant governance lead and the clinical director chaired the MDT. They were well attended by

haematology consultants as well as the matron, senior sister and CNSs. The radiologist, pathologist, pharmacy manager, RMOs, resident consultant and registrar also attended. Treatment plans were reviewed and discussion took place as to how the patients' condition should be managed going forward. We saw that peer review and challenge took place. Members highlighted areas of good practice and potential improvement, actions were agreed and outcomes documented to be shared with colleagues.

- Consultants told us about a 'virtual' MDT that took place via email, which included senior nursing staff and junior doctors as well as consultants. We were told that all patients were discussed at this forum so that all staff were aware of each patient's treatment plan.
- Oncology patients were discussed at the appropriate trust speciality MDT and outcomes were communicated back to their care team via the central electronic database (CDR) which could be accessed by staff on the wards.
- A weekly holistic MDT was attended by CNSs and representatives from the international liaison, psychology, complimentary therapies and pharmacy teams. This meeting was used to discuss the individual support requirements of each patient. Palliative care staff were also invited to attend if available.
- Pharmacists were involved in ward rounds, huddles and MDT meetings and were seen as an integral part of the medical team. They worked closely with NHS colleagues if patients were transferred to ITU or other wards in the hospital. Pharmacy staff were involved in the training of doctors and nurses in prescribing and safe medicines management. They maintained the register of intrathecal practitioners and monitored the training outcomes.
- The ward had a full-time physiotherapist who had recently taken on the role of 'falls champion' for the ward and had trained as a manual handling trainer so that they could provide support to colleagues on the ward.
- Palliative care services were provided to the ward by a service level agreement (SLA) with a neighbouring NHS trust. The palliative care team had provided recent end of life care training to ward staff. Nursing staff told us that they could easily access support from this service and that any patient referred would be seen by the team within 24 hours.
- Link nurses were available for infection control, dementia and end of life care. The end of life link nurse attended quarterly meetings with the palliative care team.
- The ward dietitian worked closely with the catering team and told us that the team was very responsive to special requests.

Seven-day services

- There was a resident medical officer (RMO) present on the ward at all times including out of hours and at weekends. The RMO was responsible for reviewing patients on a daily basis and communicating with the patients' lead consultant. Out of hours junior doctor cover was provided under an SLA with the host trust. Two specialist registrars, one specialising in oncology and the other haematology, and one resident medical officer (RMO doctor) were available between 5pm and 8am, Monday to Friday and at all times at the weekend.
- There was a documented escalation and referral process, with the junior doctors required to report to the specialist registrars who would then escalate to a consultant if required. In an emergency if the consultant specialist was unavailable, staff would contact the relevant trust on-call consultant.
- Ward staff had access to a full range of allied health professionals, including a physiotherapist and dietitian on weekdays, between 9am and 5pm. Out of hours physio cover was available from other nearby HCA hospitals if required. There was no dietitian support out of hours or at weekends but we were told that processes were in place to support ward staff should they need to access advice out of hours.
- A tissue viability service was provided via an agreement with another HCA hospital and was available out of hours and at weekends.
- There was a pharmacy service provided to the ward Monday to Friday, between 9am and 5.30pm. Outside of these times, and at weekends, a qualified pharmacist

and pharmacy technician were available for consultation and supply of emergency chemotherapy and Controlled Drugs (CDs) via HCA's 24 hour on -call service.

- There was a SLA with the host trust for 24/7 services from surgeons, anaesthetists, physicians and radiologists and supporting services should these be required.

Access to information

- Staff on the ward used computers to access both the host trust's and HCA's records and systems allowing them to access patient and hospital information. Staff told us that policies and procedures were easily accessible via the online systems.
- MDT outcomes were communicated back to a patient's care team via the central electronic database (CDR) which could be accessed by staff on the wards.
- We saw that copies of discharge letters and all consultant correspondence were held on the electronic system. Copies were sent to each patient's GP and/or referring consultant as appropriate.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff obtained patient consent before proceeding with any treatment. All of the notes we looked at included signed consent forms. Staff were aware of their duties in relation to obtaining consent. The hospital had an up-to-date consent to treatment policy.
- Staff told us they received training on the Mental Capacity Act (MCA) annually.
- A ward-based dementia champion could provide support to staff if needed, but staff told us it was unusual to have a patient with dementia on the ward.
- The ward manager said there were no patients under deprivation of liberty safeguards (DOLS) on the ward but guidelines on the MCA were available to staff on the internet. Staff told us about a recent case where they had to consider the MCA with a patient with learning difficulties.
- We looked at records for one patient who was unwell and lacked capacity to make decisions about their care. We saw that an appropriate best interest decisions had been made about treatment and all appropriate discussions had been documented.
- Senior nursing staff carried out a monthly audit reviewing the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form of any patient that had died on the ward. The form was checked for compliance against the HCA policy. We reviewed three audits for December 2016 to February 2017, which reviewed six DNACPR forms. All forms documented that the decision had been discussed with the patient or appropriate person. One of the six forms reviewed was not signed by the consultant and an action plan had been completed to address this.
- We reviewed three sets of records for patients that had died on the unit and found that each contained documented discussions with patients and/or their families about DNACPR.

Are medical care services caring?

Outstanding ☆

Compassionate care

- During the inspection, we spoke with nine patients and five relatives. We also received six comment cards. Feedback from patients and relatives we spoke with was overwhelmingly positive about the care delivered by staff. We were told that staff were "always smiling".
- Staff went above and beyond their duty to support patients' emotional and social needs. Staff were highly motivated and passionate about delivering kind and compassionate care. Patients' cultural and social needs were carefully considered and respected. It was clear that staff valued each patient as an individual and proactively sought out ways to meet their needs.
- We saw many examples of where patients and their relatives had sent thank you messages to staff expressing their gratitude for the care and attention they had received. One relative had asked a member of staff

to type up instructions for her father's medication and had sent a thank you card saying, "it's these acts of kindness that make going through tough times more bearable".

- Patients told us about the kindness and compassion of staff and how they made the effort to get to know each patient as a person. One patient told us, "I feel they are like my family" and another said "everyone smiles, [and] calls me by my name." One patient told us they had been a regular patient for long-time and said they consistently received "amazing care". Another patient spoke very highly of staff stating, "This is a truly outstanding unit, I have never experienced such kindness, care and compassion…the team has made a very difficult time so much more bearable".
- Patients told us that nurses responded quickly to call bells and always in a friendly and understanding way. One patient said "everyone is absolutely kind, friendly and warm."
- There were many examples of where staff had demonstrated compassion and thoughtful kindness. We heard about a wedding which had been held on the ward to accommodate a terminally ill patient and their loved ones. Catering staff personally went to speak to patients and relatives about how they could best meet their needs. We were told how the team regularly baked cakes for patients for special events such as birthdays. One relative told us how a member of staff had visited a patient at the end of their shift to provide an ice-lolly not because it had been requested but because they knew it would be appreciated as the patient was having difficulty enjoying food . One nurse told us that staff "went over and above" their job description in order to ensure patients felt cared for.
- Patients were asked to complete a patient satisfaction survey when they left the ward. This included the 'family and friends test' question which asked how likely they were to recommend a hospital to others after they have received treatment there. We saw that the results for the unit were consistently good at between 86% and 100% between October 2016 and February 2017. The response rate was also very good at between 91% and 100% for the same period. A separate 'Patient perceptions of the way they are cared for' report reviewed all 638 patient responses received by the service during 2016. The report found that 99.2% of patients said they would be 'Likely' or 'Extremely likely' to recommend the service to others. Additionally, 98.8% of patients agreed that they were treated with dignity and respect at all times and 99.4% said they were 'always' given enough privacy when discussing their condition or treatment.
- We saw that staff respected patient's privacy and always knocked and asked for permission before entering a patient's room. We saw that signs had been added as appropriate to remind male staff members to allow additional time for female patients to maintain their privacy and dignity in line with their religious and cultural preferences. The interpreters attending the ward rounds were respectful of patient privacy and did not go into patient rooms if their services were not required.
- We were told by several patients that staff were always very respectful of their privacy and would leave the room if the patient received a phone call. One patient said, "they [staff] respect me as a person during physical care". Another patient said "once the doctor came when I was praying, she left and came back later."

Understanding and involvement of patients and those close to them

- Patients and those close to them were treated as "equal partners" in the care delivered by staff. Patients told us they were presented with options were given sufficient information to allow them to make informed decisions about their care. Staff encouraged patient's involvement in their own care and to ask questions if they were unsure about anything.
- The 2016 patient survey asked patients whether they were involved, as much as they wanted to be, in decisions about their treatment and 96% of respondents said 'Yes, definitely'.
- Each patient was provided with a named clinical nurse specialist (CNS). The CNS provided information about chemotherapy treatment and where appropriate would use an interpreter to translate to ensure the patient and their family fully understood what was being discussed. We were told that when breaking bad news the CNS would always use an interpreter where it was appropriate.

Medical care

- Patients told us that they were very happy with their treatment and expressed confidence in the staff who cared for them. Patients told us they felt involved in their care and could speak to a consultant, or any member of their care team, any time they needed to.
- We saw that conversations between staff and patients and/or their relatives were clearly documented in patient records. We reviewed records for three patients who had recently died on the ward and saw that discussions about end of life care had taken place appropriately and relatives' wishes and concerns had been respected and responded to.
- Patients told us that they felt well informed of their options and had staff encouraged them to ask questions. One patient said, "staff give me very clear explanation and ask me if I have any questions. This happens every day" and another patient said, "They tell you the options and I feel involved" and another said, "I feel completely comfortable asking staff questions, they are very accommodating."
- Patients also told us that staff provided them with choices and that they felt they were listened to. One patient said, "the doctors came to talk to me and gave me a choice", and another patient said, "they do give me choices and my choice is respected", and a further patient told us, "they talk and listen to me, they never rush off."
- The international liaison team were the key point of contact for all overseas patients; we saw how they played a vital role in ensuring patients, and their relatives understood and were included in any decisions being made about care and treatment.

Emotional support

- Clinical nurse specialists (CNSs) were assigned to each patient and acted as a key point of contact for any support the patient required. Each patient's holistic needs were assessed at a weekly MDT held on a Tuesday morning. These meetings were attended by CNSs, therapies and support staff including a psychologist and representative from palliative care where possible.
- Complementary therapy was available to inpatients on the ward provided via the cancer centre. Reflexology and massage services were provided on the ward three times a week. Patient feedback was consistently positive about the complimentary services provided. One patient said it was a "hugely positive association with chemo" and another said they found the reflexologist "very relaxing and comforting" and said "her healing hands always helped me feel calmer" and another commented the service was "a real treat during a period when you most need and appreciate it."
- Two HCA employed psychologists visited the ward regularly. This included an Arabic speaking psychologist. The international patient manager told us that patients responded positively to this service as it meant there was no need for an interpreter to be present at the counselling sessions and therefore patients' privacy was maintained. Feedback from patients we spoke with was that they were seen regularly by the psychologist and found these sessions very helpful. Patients told us that they were seen at least twice a week by a psychologist and one patient said "I can call them for support when I need them."
- The cancer centre offered a range of workshops for patients and relatives on various topics including coping with cancer and supporting a loved one with cancer. We saw that information about support available was displayed on the noticeboard in the ward reception area.
- The international liaison team went above and beyond their job description to provide 24/7 emotional support to patients and their relatives. This is included supporting patients after they had been discharged by keeping in touch as well as responding to concerns or worries from patients out of hours and at weekends, regardless of whether they were on call or not. Staff told us that the team provided dedicated support to patients and their families to help them adapt to cultural differences and ensure they felt as comfortable as possible. We saw that the international liaison team took part in the twice daily 'safety huddle' on the ward and that they contributed to the discussion by voicing any concerns that the patient had. We saw messages of thanks from patients and families, which displayed deep gratitude towards the team.

Are medical care services responsive?

Outstanding ☆

Medical care

Outstanding ☆

Service planning and delivery to meet the needs of local people

- Between October 2015 and September 2016 the service treated 322 patients, over 711 inpatient attendances (including patients who were admitted more than once).Approximately 80% of patients were treated within the haematology department and the majority of the remaining patients were admitted under oncology.
- An in-house international liaison service was provided to meet the needs of the large demographic of international patients the hospital received. The majority of international patients were from Arabic countries. The international liaison office acted as key point of contact for all international patients, and their families, throughout the patient's journey. The team were available to provide support 24-hours a day, seven-days a week, from pre-admission to post-discharge including overseeing visa applications with the embassy and acting as interpreters.
- Harley Street at UCH (HS at UCH) worked in partnership with the host trust to deliver its JACIE accredited bone marrow transplantation service. Both private patients under the care of HS at UCH and NHS patients under the care of the host trust were treated following the same guidelines and procedures and all patients were reviewed by the same multidisciplinary haematology team.
- Although HS at UCH only treated private patients we were told about at least two occasions when the service had accommodated an NHS patient from the host trust who was under the care of the same haematology team. We heard that HS at UCH had supported the host trust during a recent influenza outbreak by making beds available to NHS patients.
- There was an agreement of professional clinical services in place with a neighbouring NHS trust to provide specialist palliative care. Staff could refer patients if appropriate and the palliative care team support was available 24-hours a day, seven-days a week. Patients wishing to receive end of life care at home or elsewhere in the community, could be fast-tracked to their preferred place of care within 24hrs. We did not see any evidence that performance on meeting patients' preferred place of death was monitored. Staff said the service was mainly used for symptom management and only occasionally were they requested to provide input into advanced care planning for end of life care patients. One member of staff told us they thought that advanced care planning was often started too late and that some consultants were reluctant to accept moving patients from active treatment to palliative care. Staff told us that there were also cultural barriers to having discussions around end of life care and many patients from overseas were not open to having these discussions.
- Chemotherapy medicines were provided under a service level agreement with a local HCA hospital. Procedures were in place to ensure effective communication between the third party provider and the local pharmacy team. Medication could be manufactured and delivered within 90 minutes within office hours Monday to Friday. Out of hours procedures were in place to support emergency treatment requirements.
- The service no longer provided services to children or young people under 18 years old. This had ceased in December 2016 after an internal activity review. We were told the decision had been taken as the service had received very few referrals for children or young people. Between October 2015 and September 2016, only four children and two young people (aged 16 or 17 years) had been treated as inpatients on the ward.

Access and flow

- The service had a documented admissions process. All patients were admitted under a named consultant with practising privileges granted by the medical advisory committee (MAC). Patients for elective surgery or with acute mental health episodes were not eligible for admission. All emergency admissions, within the clinical remit of the service, would be accommodated where possible. We were told that there had never been an occasion when a planned patient admission had been cancelled due to lack of beds.
- Patients could be referred to a consultant either from their own GP or consultant, an NHS trust, via their Embassy or they could self-refer. The admitting consultant was responsible for completion of admission

documents via the admissions office. The admissions office then updated the electronic patient records system with details including treatment required and duration of stay. Medical records staff, nursing manager on duty and pharmacy staff were provided with the TCI list (to come in) in advance each day. The admissions procedure also detailed admissions processes for out of hours and for supporting patients living with a disability or requiring additional support.

- Consultants told us prior to the patient being admitted their treatment plan and consent form was completed. The consultants aimed to discuss all new patients at an MDT meeting before admission, however if this was not possible the patient was reviewed at the next available MDT after admission. Pharmacy staff were aware if a patient had not been discussed at MDT and would not release treatment until evidence of MDT outcomes had been seen.
- Patients told us that treatment was arranged in a very timely manner and that they only had to wait "hours not days" between consultation and treatment. The service did not monitor patient referral to treatment times as this is only a requirement for NHS providers. However we were told that there was no delay for patients and they could be admitted to the ward immediately if required. Patients told us they were seen regularly by their consultant and that there were no issues with contacting them out of hours or at weekends. One patient told us it was "fantastic having a consultant at the ward at all times" and another said, "I just pick up the phone and I can talk to my lead consultant, even at weekends."
- Staff said the service level agreements in place with the host trust worked well and that escalation and access to the intensive care unit (ICU) and isolation wards was good. During the inspection, two patients were in the trust isolation ward. A third patient developed an infection and required isolation but as no space was available staff used contingency plans to 'reverse cohort' the patient into a room on the ward which would reduce risk of cross-infection.
- Staff followed documented procedures for emergency admissions. If a patient attended A&E, the ward team were contacted and the patient could be transferred immediately to the ward or to ICU if appropriate. All patients were provided with a card which contained their consultants' details. International patients were told to contact the international team in case of emergency and they would liaise with ward staff to advise on next actions.
- Nursing staff completed a discharge checklist for all patients who were ready to leave the ward. A copy of the checklist was provided to the patient to take away. The checklist confirmed that the consultant or CNS had assessed the patient as fit for discharge. Medical staff completed a discharge summary letter for the patient's medical records.
- Senior nurses carried out a monthly discharge audit to measure compliance with the documented procedures for discharging patients. Audit results for November 2016 showed 95% compliance with discharge standards; however, the audit found areas for improvement, which included not all patients had a completed discharge summary letter available in their medical notes. A detailed action plan had been completed to address this and the other issues identified.
- All prescriptions for discharge were prepared in advance and pharmacists undertook counselling to support people in taking their medicines. Where the patient did not communicate in English, the pharmacy worked with the service's international team to ensure they understood.

Meeting people's individual needs

- Staffing levels ensured that staff had time to spend with patients to ensure their individual needs were met. Patients told us that staff had time to talk with them and were genuinely interested in listening to what they had to say. Staff showed us a recent patient letter that thanked staff for the care they had received on the ward. The patient said, "Your positive attitude and warm personality made all the difference in my life in a time of great crisis…cancer weighs heavy on the heart but your kind words and genuine interest in me made it easier to bear."
- Staff were motivated and passionate about providing individualised care and we saw that patients' needs were always made a priority. For example, the ward physiotherapist told us that they had been spending extra time with one patient to ensure they fully

understood the exercises they needed to do. We heard how one patient, who did not have any family with him, had been keen to do his own laundry and how a member of staff had offered to support him to do this.

- Although there was no formal holistic needs assessment, we were told one was in the process of being developed. The senior sister said a weekly holistic assessment MDT took place on the ward and was attended by CNSs, interpreters, therapies, psychologist, pharmacy and other support staff. We also saw that patients' holistic needs were discussed frequently at the daily handovers and huddles. Issues that were important to patients were discussed, including laundry and noise at night. One nurse knew it was their patient's birthday that day and made other staff aware at handover. One member of staff knew that their patient had difficulty sleeping, as their neighbour liked to fall asleep with their TV on, and therefore reminded staff to switch this off once the patient was asleep.
- There was a corporate policy outlining how staff should support patients living with dementia, although the matron told us it was extremely rare that a patient requiring this support would be admitted to the ward. Staff could discretely identify vulnerable patients requiring additional support using the 'forget-me-not' scheme where a small designated magnet was placed on the door of the patient's room to make all staff aware of their additional needs. A dementia 'passport' was used to identify each patient's individual needs and personal preferences. All staff completed training in dementia awareness as part of their mandatory safeguarding adults training.
- Patients could receive visitors on the ward at any time day or night. Administrative staff were present at the reception during office hours and out of hours visitors could ring a buzzer and nursing staff would let them through the security doors. Relatives were able to stay with their loved one if they wished; each patient had a private room with space for a foldout bed if required.
- International patients had 24/7 access to an in-house interpreter team. Interpretation services were provided by the international liaison office. Two ward-based interpreters attended ward rounds, staff safety huddles and MDT meetings. Patients and relatives were consistently positive about the support provided by the international team. All patients were provided with the team's mobile numbers so that they could access support out of hours and at weekends. The international liaison team were actively involved in supporting bereaved relatives and helped them with any paperwork required by the embassy.
- One relative told us how the team had sorted out financing issues with their embassy, which had allowed them time to focus on their loved one's care.
- The service used the host trust's hospital chaplaincy service which was multi-faith. Patients had the option of having their own spiritual and religious advisors visit them at any time. We heard that that one patient who was of orthodox Jewish faith had the support of his rabbi on the ward during his final days of life.
- The international team also carried out cultural awareness training for all ward staff. We spoke with the clinical practice facilitator (CFP) who told us that all new starters received these sessions as part of the induction and showed us some of the training materials used during the session. Staff told us that this training had helped them to better understand their patients' cultural and religious beliefs and better identify their individual needs.
- International patients said their specific cultural and religious needs had been met in full by the service. One patient told us he was able to respectively pray four times a day, had access to a full halal menu and that an interpreter was "immediately made available for him". Another said, "I can pray at flexible times and I am respected". Another told us they experienced "no cultural barriers" in being treated outside of their home country. The patient feedback form was available in Arabic so that patients could complete it without assistance.
- Staff consistently demonstrated respect for the cultural and religious views of patients. One female patient told us that all staff were very respectful of their wishes to only be seen by female staff, if they needed to be seen by a male doctor they gave sufficient notice to allow her to cover her head with her scarf. Staff had placed a sign outside her room that reminded staff to knock and to wait a few minutes before entering.
- Patients and their families had access to multi-lingual psychological counselling services, provided by agreement with another local HCA hospital. The cancer

centre provided complementary therapies including reflexology and massage on the ward. Patients' feedback on these services was consistently positive, although availability and frequency of the service was identified as an area for improvement

- Information leaflets on variety of subjects related to cancer care were available in the reception area along with a noticeboard with information for patients and relatives such as support workshops including managing cancer and coping skills. A 'you said, we did' poster displayed information about what action had been taken by the service in response to patient and staff feedback.
- The cancer support leaflets included a range for relatives "be there for someone facing cancer", "coping when someone close to you has cancer" and specifically for patients "feel more like you", "emotional effects of cancer" along with covering a wide range of topics such as eating, tiredness, hair loss and relationships. Although these leaflets were not available on the ward in other languages we were told the international team could access materials in other languages if needed and spent time going through any information with patients on a one to one basis.
- The service had, as the result of feedback, recently introduced a 'quiet room' on the ward for relatives to sit and relax away from the patient's room. Visitors could make hot and cold drinks within two 'beverage bay' areas.
- Patients had access to an extensive food menu. The chef told us 160 choices were available and 160 more were in the development process. All food was prepared from fresh ingredients and nothing was kept frozen. Gluten free, vegan and halal diets were all catered for and a separate Arabic menu was also available. The dietitian worked closely with the catering team to meet patients' specific needs. A nutritional analysis of all menu items had recently been completed and higher energy choices were clearly labelled on the menu.. Menu was changed on a four-week cycle and patients were usually asked to make their hot food choices the day before, however, we were told by staff that the chef was very responsive to short-notice and special requests. Feedback from patients about the food choices was generally very positive. We were given examples where the chef had anticipated patients' needs or had spent time reviewing the meal options with patients. One patient told us that because of the side effects of their treatment, they had not been enjoying eating food and had been able to specially request dishes that were not on the menu.
- Ward staff had attended a palliative care study day which had been led by the palliative care team. Sessions covered symptom management and the emotional side of dealing with death. Patients who died on the ward were transferred to the host trust's mortuary. Doctors on the ward were able to produce the death certificate straightaway preventing delay to the family. If the family wished to view their loved one after death staff would make arrangements with the mortuary, however viewing was not currently available out of hours and at weekends. We were told about plans to train several nurses on the inpatient unit to enable them to carry out the viewing, which would then reduce any delay to the family.
- One relative told us their family member had been an inpatient on the ward for over a month and had been seen by the Arabic speaking psychologist regularly. The first time the psychologist had visited, she had automatically arranged with ward staff for the patient to be moved to a bigger room with a better view without having to be asked. The relative was grateful for this as they felt their loved one's needs had been anticipated and thoughtfully considered.
- The physiotherapist had developed a range of information leaflets for patients and spent time explaining to patients how to complete beneficial exercises. Staff on the ward were full of praise for the enthusiasm he displayed in actively seeking out new ways of helping patients and colleagues. We were told that he went the extra mile to spend time with patients to ensure they fully understood the information provided.

Learning from complaints and concerns

- The service reported receiving nine formal complaints between October 2015 and September 2016.
- We reviewed the service's complaints log for June 2016to November 2016. Of 10 complaints recorded, eight related to the inpatient ward, of which five were recorded as formal complaints and three informal. All complaints had a description, action taken and outcomes. Date of receipt, acknowledgement and

response were recorded. In all cases a full response, or holding letter, had been provided within the appropriate timescales. In each case senior staff had provided an apology and action taken to address any areas for improvement. We saw that actions taken included arranging additional staff training and feedback shared with staff during safety huddles.

- We saw information on how to raise concerns, provide feedback or make complaints was available in each patient room. A 'Guide to Making Complaints and Comments' was available as part of the patient's admission pack, on the website, and on the unit.
- The service used HCA's complaints policy which clearly sets out the roles and responsibilities, as well as timescales, for managing patient formal and informal complaints.
- All formal complaints were logged on to the service's electronic incident reporting system. There were systems and processes in place to acknowledge, investigate and respond to complaints within a defined period of 20 working days. Numbers of formal and informal complaints were submitted to the central HCA dashboard and trends and themes discussed by senior staff both locally and nationally.
- The chief executive officer (CEO) had overall responsibility for managing complaints. The head of governance and risk was responsible for the governance of complaints investigation by supporting heads of department to respond to complaints and to ensure response times were adhered to. If a complaint was about a consultant the medical director was informed. All complaints were reported to the quarterly medical advisory committee (MAC), which was chaired, and attended by consultants, the CEO, and hospital senior management staff.
- Senior leaders discussed all complaints at the monthly governance meeting, which was attended by all heads of department, and chaired by the head of governance and risk. All complaints were also discussed at the monthly divisional compliance and risk meeting chaired by the CEO. Ward staff received feedback via email, daily safety huddles and monthly team meetings

Are medical care services well-led?

Outstanding ☆

Leadership and culture

- The service had a highly visible, passionately engaged senior leadership team. We saw excellent examples of partnership working and there was a strong culture of collaboration within and between teams and various professionals involved in patients' care and treatment. Staff spoke highly of each other and of the relationship they had with external organisations including the host trust.
- Staff on the ward were managed by the matron, who reported to the clinical services manager (CSM). The CSM was responsible for managing all junior doctors and then reported directly to the hospital's chief operating officer (COO) who was also the registered manager for this service.
- The matron and CSM formed part of the hospital's clinical management team, which included the leads for governance and risk as well as the MAC chair and clinical director. The clinical management team was overseen by the executive management team formed of the CEO, COO and chief finance officer.
- The matron led a team which included CNSs, ward nurses as well as the allied health professionals including the physiotherapist and dietitian. The matron was also responsible for overseeing the day care staff based at the outpatients' site on the fifth floor of the cancer centre. The senior sister and ward sister were responsible for day-to-day management of the ward.
- All staff we spoke were aware of the local management structure and spoke highly of managers and senior leaders. Staff said that the matron and CSM were visible on the ward daily and that the senior managers visited regularly and attended staff meetings. Staff said that managers at all levels were very approachable and encouraged staff feedback, one member of staff praised managers saying they "always have time for you."
- Staff told us that everyone was treated equally and their opinions were respected regardless of role or grade. Staff had a strong sense of teamwork. Nursing, medical and allied health professionals all collaborated to prioritise delivering high quality, compassionate

patient-centred care. Staff told us, "We are a family", "everyone works together" and "everyone supports me." A member of staff who had really joined the service said, "All staff have made me feel welcome to the team and have gone the extra mile to help me settle in." Agency and bank staff told us they felt they were made to feel part of the team.

- Senior staff promoted an open and transparent culture, feedback from patients and staff was actively encouraged and staff felt confident in reporting concerns or near misses.
- Staff said they were encouraged and supported to train and develop and that there were many opportunities to develop professionally. Staff told us they were proud to work for the organisation and were passionate about providing excellent patient care.
- Staff sickness rates for inpatient nurses were lower than the average of other independent acute hospitals for October 2015 and September 2016. Inpatient nurse turnover rates had reduced by almost half between October 2015 and September 2016 compared to the previous 12 months, improving from 44.7% to 27.8%. Senior staff told us about ongoing measures to retain highly skilled nursing staff to improve this further.

Vision and strategy

- The service's own vision, "Exceptional people, exceptional care", and HCA's company values were clearly displayed on the ward for patients and relatives to see.
- The values were based around staff working as a team to deliver patient-centred care with compassion, kindness and integrity. Staff we spoke with understood the vision and values and actively demonstrated them in their daily delivery of patient care. Staff understood, and were passionate about, delivering compassionate patient-centre care to all patients. We were told by one member of staff that their aim was "to do the best we can for our patients."
- The strategy for the service focused on operational excellence and delivering high quality, accessible care. This aligned with the overall organisational strategy for HCA.
- Local strategic objectives for the development of the service were set out within the annual governance and improvement plan and were aligned under CQC's five domains of safe, effective, caring, responsive and well-led. Objectives included promoting an open and transparent culture, listening to stakeholders and empowering and involving patients in their care. All objectives were supported with measurable actions and assigned to a responsible person or team.
- The matron and senior nursing staff were responsible for the ward specific service plan that set out how quality improvement objectives would be achieved for the following 12 months. This included plans for service development, staff education and quality assurance as well as risk management. The objectives were recorded on an annual inpatient service plan and clearly linked and aligned with the wider business objectives of the service and provider.

Governance, risk management and quality measurement

- We found that governance structures were robust and well-embedded within the service. Escalation processes and lines of accountability as well as individual roles and responsibilities were clearly documented and understood by staff.
- The medical advisory committee (MAC) worked as an advisory body that provided advice regarding strategic and medical matters and admitting practicing privileges. The MAC met quarterly and was well attended by both haematology and oncology consultants and chaired by a senior haematology consultant.
- We reviewed the MAC meeting minutes for November 2016 and saw that the meeting was well attended by a range of clinical staff including consultants for haematology and oncology and leads for the radiography and physicist teams. The minutes were very comprehensive and the agenda covered a range of items including practising privileges, staffing, MDT attendance, mortality review and audit results. There was also a detailed review of incidents, safeguarding and patient feedback.
- Heads of department were supported by the head of governance to review departmental risks. A corporate risk strategy helped guide identification and

management of risk. The aims of the strategy were to encourage openness and transparency and raise staff awareness of risks and share learning. It stated that risk management was the responsibility of all staff.

- Senior staff were aware of the risk register and could tell us what the main risks to the service were. Each risk on the risk register had a review date, was assigned a risk level and had detailed controls and measures in place to address them. We saw that senior staff regularly reviewed risks during monthly governance and risk meetings.
- The CEO, COO, head of governance and risk and CSM all attended a regional monthly compliance and risk meeting where incidents, complaints and risks were reviewed and learning and best practice shared between HCA sites. For example, to address the risk of patient falls HS at UCH had given the ward physiotherapist the role of 'falls champion' to support ward staff. This was taken forward as best practice and implemented at other HCA sites.
- The head of governance and risk chaired the monthly governance meetings. The meetings covered a range of standing items aligned with CQC's five domains of safe, effective, caring and well-led. Incidents, risks, patient feedback and audit outcomes were all reviewed by senior staff on a monthly and quarterly basis.
- We reviewed the quarterly clinical governance meeting minutes for February 2017. The meeting was chaired by the consultant governance lead with attendance from heads of department, the CEO, medical director, head of governance and risk, matron, CSM and pharmacy lead. There was a detailed review of all patient deaths, infection control, safeguarding, incidents, complaints, patient feedback, audit results, NICE guidance and safety alerts and feedback from the trust's governance meetings.
- The service had good links into the host trust's governance structures. Senior leaders also attended a number of the host trust's governance meetings including, infection control, emergency planning, haematology governance, radiation protection committee and transfusion committee. Feedback from these meetings was discussed at the quarterly clinical governance meetings.
- The COO had recently completed a full review of all service level agreements (SLAs) with the host trust and had produced standard operating procedures (SOPs) for each SLA so that staff knew how to access services. SLAs were reviewed regularly at monthly, quarterly and annual meetings with the trust.

Public and staff engagement

- Staff asked all patients to complete a patient experience survey. The survey was also available in Arabic to meet the needs of the largest demographic of international patients. Senior staff discussed survey results monthly and action plans to address areas for improvement were reviewed at the monthly operational and governance meetings. Results were also shared with staff on the ward. Patient satisfaction results and feedback were displayed on a screen in the staff room along with the values and vision of the service.
- Patients were asked to provide specific feedback for any supportive services such as complementary therapies they had accessed. We saw the results of the 2016 survey which 42 patients had completed and 100% said they found the benefits of complementary therapy 'very good or good'.
- Senior managers told us about plans in place to set up a specific patient forum where further feedback would be gathered and used to improve services.
- Staff took part in a two-yearly HCA staff survey to provide anonymous feedback on how they felt about their job, manager and department. The service was unable to provide specific survey results for staff as they were combined with those of staff at two other HCA sites. We were told this was because many staff worked across more than one site and the senior management of all three sites, including governance was shared. The service had however developed a site-specific action plan to address any areas for improvement, for example, a financial incentive scheme had been introduced to reduce staff turnover and help retain skilled staff.
- We reviewed the 2016 staff survey results for the organisational group and overall we saw high levels of staff engagement. Ninety-six percent of staff said they agreed or strongly agreed that they were committed to doing their very best for their facility, 93% of staff felt trusted to do their jobs, 86% said they were proud to work for the organisation. Eight-two percent said they

were confident that they could raise an issue with their line manager without it being held against them and 78% said they felt encouraged to put forward ideas for improvement.

- Staff could pass on feedback to senior managers using a feedback box available in the staff room. We saw a feedback board with a 'You said, We did' poster, sharing the actions taken in response to their suggestions.
- There was a staff reward and recognition programme including an 'employee of the quarter' where staff could nominate a colleague for an award. We spoke to one member of staff who was proud to tell us they have been successfully nominated as 'employee of the quarter' by the ward staff.
- We saw several emails sent by the ward sister to all nursing staff on the unit passing on thanks from patients and their families and thanking staff for their commitment and compassion.

Innovation, improvement and sustainability

- The service was working in partnership with the Sarah Cannon Research centre to give patients access to new cancer medications through clinical trials.
- External bodies including CHKS had accredited the service. CHKS is a quality assurance programme with a framework of standards that are externally audited on an annual basis and includes ISO 9001 accreditation. Harley Street at UCH had participated and achieved accreditation in the following standards: patient focused care, risk and safety, leadership and corporate management, and oncology.
- The service provided several innovative new treatments including haploid-identical bone marrow transplant, which allows the use of donor stem cells than only match the recipient by about 50%, meaning that a donor could be found more quickly for a patient as a close family member was likely to be a match. We also heard about plans to introduce a Tumour Infiltrating Leucocytes (TIL) Therapy for patients with metastatic melanoma.
- Staff were actively supported in their professional development for example two ward sisters told us they had been supported to undertake a 12-month leadership course in 2017.
- The service had developed a unit-based safety programme that included a monthly "walk rounds" with senior leaders focussing on proactive risk management.
- Staff were actively engaged in reviewing patient outcomes. In March 2017 two CNSs presented on the effectiveness of a new chemotherapy drug at a Myeloma conference in India.
- The clinical director told us about plans to change the structure of mortality review meetings in order to meet the standards within new NHS framework for reviewing and learning from deaths. To ensure objectivity, case reviews should, wherever possible, be conducted by clinicians other than those directly involved in the care of the patient. Senior leaders told us about wider organisational plans within HCA to centralise peer review processes to improve objectivity.
- We were told about plans to open two new wards in 2020 within the host trust's new development. This would increase the number of beds to 43 and include a negative pressure unit, allowing patient's with infections to be isolated without having to move them to the trust's isolation unit.
- One of the haematology consultants had recently set up a clinic in Kuwait so that they could review patients once they had been discharged.

Outstanding ☆

Outpatients and diagnostic imaging

Safe	Good ●
Effective	
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Are outpatients and diagnostic imaging services safe?

Good ●

Incidents

- The hospital did not report any never events related to outpatients or radiotherapy in the period October 2015 to September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were a total of 211 clinical incidents reported between October 2015 and September 2016. Of these incidents, 43 occurred in outpatient and radiotherapy services. The rate of clinical incidents in outpatient services was higher than the rate of other independent acute hospitals the Care Quality Commission (CQC) holds data for. Eight non-clinical incidents were reported in the same period, which was also higher than other independent acute hospitals the CQC hold data for. This demonstrated a strong reporting culture, capturing near misses and incidents of low harm. Reporting trends were monitored and lessons learned shared with staff. For example, some staff told us they had noticed a trend for patients being discharged without a follow up appointment in place. The team reviewed the process and implemented a new procedure to make improvements to the system.
- We spoke with staff about the number of incidents and were assured that the incident reporting process was robust. Staff we spoke to were able to accurately describe the process and the use of the electronic incident reporting system. One member of staff was able to give an honest account of an incident that involved an inaccurate recording of a patient's weight. The member of staff was able to explain the reporting and documentation process and the subsequent investigation that took place. They were also aware of learning and changes in practice that happened as a direct result of the incident. The recording of weight for patients was now double checked by staff.
- All reported incidents within the organisation were fed back at the senior nurses' monthly meeting. Incident learning was also shared with wider teams at their regular monthly team meetings. We saw minutes of all these meetings, which evidenced this.
- Under regulation 4(5) of the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000, providers are obliged to submit notifications of exposures 'much greater than intended' to the CQC. We received no such notifications between October 2015 and September 2016. The radiotherapy department staff explained how an incident involving a patient's immobilisation equipment had been highlighted to the Radiation Protection Advisor (RPA) and appropriately investigated. The contracted radiation protection service did not recommend that the incident required any further action.
- Staff understood their responsibilities of the Duty of Candour regulations. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. All staff

described an open and honest culture. All staff we spoke with confirmed they apologised to patients when care was not as it should have been. We saw 'duty of candour' templates that staff said would be used as the basis for written apologies to patients if required.

Cleanliness, infection control and hygiene

- Staff had completed annual mandatory training in the prevention and control of infection. Infection prevention and control policies (IPC) were available for staff to access on the hospital intranet.
- On visual inspection, all areas we visited in outpatients and radiotherapy appeared clean and tidy. Posters prompting staff to adhere to good hand hygiene practice were clearly displayed, Hand sanitiser gel pumps were available across the areas. We observed staff using them consistently during inspection.
- There was a service level agreement (SLA) with the host trust to provide infection control services to the service. This included 24-hour, seven days a week access to a consultant microbiologist and virologist for advice and support. The SLA also provided access to the trust's infection control nurse, seven days a week, from 9am to 5pm. The service had its own standard operating procedure (SOP) providing detailed guidance to staff on how to access additional IPC support.
- The staff were aware who the infection control lead was within the organisation. The infection control nurse carried out a number of infection prevention and control audits on a monthly basis. These included an 'aseptic and clean touch technique' audit, environment audit and audits of hospital acquired infections. All audit results were discussed in the Infection Control Study Day held in December 2016.
- The host trust's IPC lead nurse produced a monthly infection control summary document based on the outcomes of audits on the outpatient areas. The matron for HS at UCH sat on the provider-wide infection control committee, which was responsible for benchmarking IPC performance across all HCA facilities.
- All staff, both clinical and non-clinical, adhered to the organisation's bare below the elbow (BBE) policy.
- The radiotherapy clinical nurses' room had a weekly regime of cleaning equipment. After cleaning, labels were attached which indicated the date and signature for when this was carried out.
- There was a daily cleaning schedule in the phlebotomy (blood sample taking) room. The day care treatment 'pods' were cleaned between each patient. Prior to the start of treatment, each patient was asked key questions about their health. A baseline temperature was also taken to ensure there was no underlying infection and that treatment was safe to administer.
- There were hand washing sinks available in all patient examination areas in line with the standard guidance related to infection prevention and control such as that related to NHS services (i.e. Health Building Note 00-09 Infection Control in the built environment) .
- Personal protective equipment (PPE) was available in the outpatient, day care and radiotherapy areas. We saw staff using this appropriately.
- The hospital used coloured disposable bags and labelled clinical bins were in place. We saw sharps bins were available in any treatment and clinical areas where sharps may be used. We saw the labels on the sharps bins had been fully completed, which ensured each container was traceable. The tab on the top of the sharps bin was pulled shut when not in use.
- All soft furnishings were wipeable and in good condition.
- We saw water was tested and results reported to the health and safety committee. This complied with the water safety management regime HTM 04-01. A Pseudomonas outbreak had been detected during routine testing of the outpatient toilets. Pseudomonas are bacteria found in the environment such as soil, water and plants. This had been reported to the infection control lead and was reflected on the risk register. We saw weekly checks were in place to monitor the situation.
- We looked at the infection prevention and control audit report from December 2016. All the actions identified had been addressed at the time of the inspection. One

action identified in the report was that not all equipment had 'I am clean' stickers. We noted during the inspection that all pieces of equipment now displayed those stickers

Environment and equipment

- HS at UCH undertook environment walk rounds on a monthly basis in outpatients and radiotherapy, in conjunction with the host trust. The host trust's appointed IPC lead also completed a monthly audit to assess both the physical environment and clinical equipment.
- The consultation rooms were all well-equipped. They included a treatment couch and a trolley for carrying clinical equipment required. The treatment 'pods' and treatment rooms in the day care unit were clean, well-kept, spacious and bright.
- Staff told us they completed a checklist each day to ensure the areas were well stocked with all the necessary documentation and equipment. We saw these completed forms kept in a folder. We noted the rooms were well stocked.
- There was resuscitation equipment available across both outpatient rooms and day care. We looked at the resuscitation trolley checklists over the previous month and found them to be checked and signed on a daily basis. The equipment followed national resuscitation council guidelines.
- Access to the radiotherapy department was via a key pad entrance system at the front of the main department within the host hospital. Clear warning signs were in place to warn of the danger of being exposed to radiation. We saw the radiation warning lights were present and in working order. These were checked as a part of daily quality assurance checks.
- A full maintenance contract was in place to support the on-going running of the radiotherapy machine. Other daily quality assurance checks, such as accuracy and radiation output, were recorded for medical physics to review any trends or outlying results. We observed staff undertaking these checks.
- We saw competency checklists to ensure staff were properly trained in the use of the radiotherapy treatment equipment.
- The radiotherapy equipment had regular servicing carried out by manufacturer engineers. We saw evidence of the manufacturers completed service reports.
- We observed radiotherapy staff wearing specialised personal protective aprons. These were available for use within all radiation areas and on mobile equipment. Staff were also seen wearing personal radiation dose monitors, which were monitored in accordance with the relevant legislation. We noted that an issue regarding the correct usage of these badges had been highlighted in the latest radiation protection report and had been addressed with staff.
- The Radiation Protection Supervisor (RPS) within the radiotherapy department carried out risk assessments. These were easily accessible to all staff to read and review.
- We saw electrical testing stickers on equipment, which indicated the equipment was safe to use.
- There was a separate room for patients to have blood tests taken which helped with control and prevention of the potential cross contamination.
- Fire extinguishers were serviced appropriately and were placed in prominent positions. Fire exits were clearly sign posted and exits were accessible and clear from any obstructions.

Assessing and responding to patient risk

- Emergency resuscitation equipment was available and all nursing and radiotherapy staff had undertaken basic and intermediate life support training for adults.
- All patients attending the day care unit had a face to face pre-admission assessment. This assessment would identify any risks to the patient based on their medical history, whether these risks could be minimised and if the day unit could safely care for them.
- There were emergency assistance call bells in all patient areas. We observed the call bells being answered immediately on the day unit.
- In the radiotherapy service, staff we spoke with knew who their RPS and RPA were. We saw the local rules and radiation regulations were in place and accessible for staff to access.

Outpatients and diagnostic imaging

Medicines

- Chemotherapy was prepared by a neighbouring HCA hospital and delivered to the location by a courier service under a SLA, which was monitored. Any delays were recorded and investigated. All chemotherapy was prescribed on an electronic system. A clinical screening and checking procedure was followed to ensure the medicines were safely prescribed and administered. Safe procedures for intrathecal administration were followed, including separate storage, training and the maintenance of a register of practitioners. Intrathecal administration is a route of administration for drugs via an injection into the spinal canal.
- All medicines were stored safely and appropriately. The medicines cupboards we inspected were locked and secure, all stock was within expiry date and there was evidence of stock rotation. Cupboards containing substances hazardous to health were also locked. Only authorised staff had access to keys for the medicines cupboard. There were no controlled drugs (CDs) kept or administered in the radiotherapy department.
- The radiotherapy department also kept their medicines in a locked cupboard. They had a separate anaphylaxis drug kit to deal with life threatening allergic reactions requiring immediate treatment.
- Fridge temperatures were monitored daily. We checked back on the previous month's records. Suitable emergency medicines, extravasation and spill kits were available and checked regularly. Extravasation is the leakage of IV fluids and/or drugs into the surrounding tissue around the site of the infusion.
- Pharmacists were involved in MDT meetings and daily planning sessions with nursing staff. They were seen as an integral part of the medical team. Each patient had an individual pharmaceutical care plan prepared before their first treatment. Pharmacists undertook personalised sessions to support people in taking their medicines, including preparing individual compliance plans. Where the patient's first language was not English, the pharmacy worked with the service's International Office to ensure they understood any instructions regarding their medications.
- A medicines management committee met regularly. This was chaired by the lead pharmacist. One of the roles of this committee was to discuss new protocols and medicines. All new protocols were supported by clinical evidence, and were checked and signed off by two consultants and a pharmacist. . Drug alerts were actioned by the pharmacy. We saw one recent staff bulletin which outlined changes implemented as the result of an alert.
- Staff were aware of the policies involving medicines management and knew where they were located in the department and on the staff intranet.
- Emergency drugs were kept on the shared resuscitation trolley and checked daily.

Records

- From October 2015 to September 2016, no patients were seen in the outpatient department without the full medical record being available. This included medical records from previous visits and any other previous diagnostic and test results.
- Records for outpatients were stored securely in the medical records department on-site. The notes were available for clinics and then taken back to medical records or the outpatient storage location. These locations were safe and secure and could only be accessed by authorised staff.
- Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual log-ins.
- Staff and consultants were not permitted to remove any hospital records from the site without prior permission from the Clinical Service Manager. All consultants were registered with the Information Commission Office as data controllers. Security bags were used to transfer records outside of the hospital premises, such as when a patient was being transferred to another HCA facility. Records were transported internally in locked trolleys.
- All imaging, histology and blood results were available electronically.
- We saw that the radiographers had completed their records accurately by checking patient identification and recording patient dose information.
- We also saw evidence that the radiographers had checked and documented patient pregnancy status, in line with departmental protocol.

Outpatients and diagnostic imaging

- We reviewed six patient records which were completed with no obvious omissions. Records were legible and signed and contained referral letters, results and discharge letters.
- All staff we spoke with had completed information governance training. Records showed 100% of staff had completed this training.

Safeguarding

- HS at UCH no longer provided any outpatient or radiotherapy services to children under the age of 18, they stopped providing the service in December 2016 under undertaking review of the service.
- We spoke with staff in the service and they had a good understanding of the policies and procedures to follow for both children and adults' safeguarding issues. All of the staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They could access support from senior staff if needed.
- All staff in the department were trained to level 1 and 2 adults safeguarding.
- The safeguarding training across the hospital met the requirements of the Intercollegiate Document 2014. Safeguarding level 4 training was held by the Chief Operating Officer, with delegated day-to-day responsibility to the matron, who was also trained to level 4.
- We saw policies were in place and in date for both safeguarding children and adults. There were no safeguarding concerns reported to the CQC in the reporting period from October 2015 to September 2016.

Mandatory training

- Mandatory training included subjects such as infection control, health and safety, fire safety, conflict resolution, information governance and safeguarding.
- Mandatory training was delivered mainly online, through e-learning courses. Staff told us the 'learning academy' set up by HCA was excellent and they were able to attend seminars and masterclasses on various topics.
- Senior staff told us they regularly reviewed the staff's compliance with mandatory training. We saw mandatory training compliance rates in the last twelve months ranged from 92% to 100% against a target of 90%.
- Outpatients were supported by the clinical practice facilitator (CPF), who was responsible for monitoring training compliance and training new starters

Nursing and Allied Health Professional staffing

- There were dedicated nursing, patient support staff and radiographers across the outpatients and radiotherapy departments. These staff had the right qualifications, skills and experience to meet the needs of the patients.
- The outpatient department had five nurses and four clinical nurse specialists (CNSs). Staff could utilise cross-cover arrangements with the in-patient ward if required. There were two bank nurses available to cover any additional shifts. There were currently no vacancies for registered staff. One CNS post had been recruited into but the candidate had not yet started.
- Senior staff told us they could adjust the number of staff needed to cover clinics to help during busy times, or where patients had greater needs.
- There were four radiography staff in radiotherapy, with a cross-site service lead across other HCA radiotherapy centres. There was one dedicated radiotherapy nurse. Staffing cover for annual leave or sickness was provided using a 'buddy cover' system, with one of the junior sisters on the chemotherapy unit.
- Sickness rates for outpatient nurses were 0% in the reporting period October 2015 to September 2016.There was no use of agency staff.
- There were no vacancies for outpatient healthcare assistants on the day of our inspection and no staff turnover for this staff group from October 2015 to September 2016.

Medical staffing

- Consultants who held clinics were responsible for the care of their patients. Secretaries organised the clinic lists around consultant availability.
- There were 174 consultants recorded as having practicing privileges at the hospital. Of this number, 79%

worked regularly at the hospital undertaking 100 or more consultations (October 2015 to September 2016). A further 21% of consultants undertook between 10 and 99 consultations in the same time period.

- There was one substantive resident medical officer (RMO) dedicated to the day care unit. They worked from 9am to 5pm, Monday to Friday. An SLA was in place with the host trust to provide 24/7 services from medical staff as required.
- There was a medical advisory committee (MAC) responsible for consultant engagement. For a consultant to maintain their practising privileges at the hospital, there were minimum data requirements with which a consultant must comply. These included registration with the General Medical Council (GMC), evidence of insurance, and a current performance appraisal or revalidation certificate. In speaking with the chair of the MAC and the medical director of the service, we were assured this process was followed.

Emergency awareness and training

- HS at UCH had policies and procedures in place to ensure business continuity. This included what to do in the event of internal incidents, major incidents and emergency preparedness. During the inspection a major incident occurred in London. The senior team were immediately briefed and plans were put in place for any response required.
- Staff in both outpatients and radiotherapy were aware of the policies and how to locate them on the electronic system.
- We looked at the radiotherapy business continuity plan and saw it was up to date.
- Staff told us there was regular testing of fire alarms and they knew where the fire assembly point was. They were aware of how to evacuate the patients and staff within their immediate areas. Overall compliance for fire safety training for all staff groups in outpatients and radiotherapy was 98%.

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- We saw the two latest IR(ME)R audits, which demonstrated compliance with regulations. The reports noted that there was generally a high standard of radiation safety associated with radiotherapy but were some areas of improvement recommended to be able to achieve best practice. Action plans on these recommendations had been developed and updates given at team meetings.
- The radiotherapy service had a radiation safety policy in place, which met with national guidance and legislation. The policy set down certain roles, responsibilities and duties of designated committees and individuals.
- The radiotherapy service carried out quality control and physics checks to ensure the service met expected standards.
- Clinical staff knew of and used the relevant NICE guidelines relevant for their departments. These guidelines could be accessed easily through the intranet. A central HCA team supported the service to remain updated and informed them of any changes to guidance. Staff told us any updates were discussed at the governance and risk meetings.
- Both outpatients and radiotherapy undertook clinical and non-clinical audits. We looked at the recent radiotherapy compliance audit for with the NHS Cancer Waiting Times. This showed 98.3% compliance. For palliative patients, the average wait was 11 days within a 3-22 day expected range from the decision to treat date.
- There was one incidence of non-compliance against the waiting time targets of 3-22 days for a patient commencing radical radiotherapy. This was confirmed by the records as patient choice.
- There was a range of standard operating procedures (SOP) within outpatients and radiotherapy. Any new SOPs were cascaded to all staff for reading and signing.

Pain relief

- Consultants discussed pain management within the consultation process.
- The patients we spoke with had not needed pain relief during their attendance at the outpatients department. However, one patient told us they were suffering from severe pain at home. They were able to text the nurses who responded immediately with support and advice.

- The resident medical officer (RMO) was also available in the event of a patient requiring a review of their pain management.
- Staff in radiotherapy told us they had admitted a patient to the inpatient ward to get the patient's pain under control so they could continue with the radiotherapy procedure.

Nutrition and Hydration

- Patients attending the day care unit were provided with a range of drinks and small meals.
- There were cafes on the ground floor of the cancer centre for purchasing drinks and snacks.
- Patients and relatives also had access to a patient lounge area where they could use a hot drinks machine.
- Patients completed a nutrition assessment at the start of their day care visit. The information from this assessment was shared with the kitchen staff, who would ensure they prepared food tailored to the persons nutritional needs, feeding abilities and food preferences. Staff had access to a dietitian if further support was required.
- Nursing staff on the chemotherapy unit were able to directly refer a patient for an in-patient admission if any additional intravenous hydration was required.

Patient outcomes

- There was a good range of local audits and initiatives within the radiotherapy and outpatient department to monitor and report on patient outcomes. Audits included record keeping, patient satisfaction and consent.
- We looked at the audit schedule for 2016, which covered audits such as chemotherapy documentation and radiotherapy doses.
- There was no evidence of the outpatients department taking part in national audits. This was due to the low number of patients seen on an annual basis. Staff, however, told us the haemopoietic stem cell transplantation service was accredited by the Joint Accreditation Committee (JACIE) (haematopoietic stem cells are cells that support he formation of blood cellular components). This meant the effectiveness of the service was externally reviewed and performance measured in accordance with agreed standards of excellence.
- The clinical nurse specialists (CNS) told us they were due to implement the electronic Holistic Needs Assessment (eHNA) eNHA is a care plan that ensures that people's physical, practical, emotional, spiritual and social needs are met in a timely and appropriate way, and that resources are targeted appropriately. The contract had been agreed but not yet implemented. The eHNA would enable the person affected by cancer to complete a questionnaire, which would be sent to a clinician through a secure website to develop a care and support plan.
- CNS staff also told us the day care patients complete a personalised diary and set their own health goals and desired outcomes.

Competent staff

- We saw all outpatient and radiotherapy staff had their appraisals completed in the current year to date. Staff told us the regular appraisal and six-monthly reviews allowed support and monitoring of personal development. Staff told us the opportunities for development were excellent.
- All nursing staff had a standardised corporate induction programme, within the first few weeks of starting with the organisation. They had to achieve key clinical skills training. For example, drug administration, chemotherapy management and administration, venepuncture and intravenous drug administration. Staff had to pass specific competences with a mentor before they were allowed to work alone. All newly appointed nursing staff were aligned to a mentor who supported them throughout their induction period.
- The clinical practice facilitator (CPF) worked alongside staff when learning needs had been identified on the annual personal development plan (PDP). Staff commented that they were supported to take every opportunity to learn, either through on line training, internal in house learning sessions, or by attending external conferences. One member of the nursing team had recently presented a paper at a significant conference in India. Staff were also encouraged to take on new roles, or take the promotion opportunities

within the nursing teams. They expressed how much they had been supported and encouraged to take on this new role. The CPF took responsibility for ensuring staff had the relevant training to enable them to support the specialist nature of their work.

- HR monitored the nursing revalidation process but staff were supported in collating their evidence by the CPF. Revalidation is a new process since2016 where nurses and midwives need to demonstrate to the Nursing and Midwifery Council that they can practice safely and effectively.
- We saw evidence that nurses, radiographers and other professionals had appropriate skills, knowledge and experience to carry out their roles effectively. We looked at competency check lists and saw these were completed and signed.
- Staff administering radiation were appropriately trained to do so. We spoke with the radiographers who showed us records demonstrating their compliance with the IRMER regulations.
- Any concerns related to the consultants around their competency was dealt with via the 'Responding to Concerns' policy. A local decision making group was in place to discuss any issues. On-going compliance with practising privileges was monitored on a monthly basis.

Multidisciplinary working

- There was evidence of good team working. Staff felt the small team sizes meant they all got to know each other well and worked well together.
- The weekly multidisciplinary meeting allowed input from nursing, medical and allied health professional staff. Staff told us consultants were approachable and always willing to give help and advice. One member of staff in radiotherapy told us they felt confident to challenge a consultant decision, in the best interests of patient safety, if required to do so.
- We attended the outpatient daily huddle meeting which was attended by the nursing team, administration team and pharmacy. This meant the patient pathway was reviewed by all the key staff involved and any issues addressed prior to the patient starting treatment.
- We heard positive feedback from staff of all grades about the excellent teamwork. Staff worked towards common goals, asked questions and supported each other to provide the best care and experience for the patients.

Access to information

- All staff we spoke with told us and we saw they had access to trust policies and procedures on the intranet. Staff were positive about the electronic access and felt they were always updated on relevant information via email and meetings.
- No patients were seen in outpatients without a paper or electronic record being available.
- We were told that no consultants took the notes off site and this practice was reflected in the information governance policy.

  Access to blood test results and imaging was provided electronically, which made them promptly and readily accessible to staff in the outpatient clinics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw consent documented in the medical records. This showed patients had consented to treatment and knew the expected benefits and risks.
- We saw forms in the consultation rooms but did not directly observe consent being taken in outpatients. One patient on the day unit told us the doctor had undertaken the consent process thoroughly and explained the risks and side effects of their procedure. They had been given a copy of the consent form.
- Staff also sought consent to share information with the patient's GP. The patient would also receive a copy of any correspondence. One patient commented how useful this was, as it kept them informed as they were often unable to recall all the information given to them during consultations.
- Verbal consent was observed in the radiotherapy room. The consent process included a discussion of the risks to the patient and an opportunity for the patient to ask further questions.
- The provider had a policy in place to guide staff in the correct use and interpretation of the Mental Capacity Act

2005 (MCA). Staff completed this training as part of the mandatory training programme and had an understanding of issues in relation to capacity and the impact on patient consent.

Are outpatients and diagnostic imaging services caring?

Outstanding ☆

Compassionate care

- Without exception, patients told us they were treated with kindness, dignity, respect and compassion. We observed staff treating patients in a kind and considerate manner. It was evident from all our conversations with staff that the patients were at the centre of everything they did. This was supported fully by the patients we spoke to, as they all expressed positive views about their experiences at the hospital. One of the patients we spoke to during the inspection said, 'the nurses are great and the doctor is brilliant. They are all so supportive and caring.'
- Staff in the administration team told us they always observed the nursing team going the "extra mile" for patients. Examples included giving ideas of where to visit locally if waiting in the clinic for any results, facilitating convenient appointment times and celebrating special occasions such as a birthday. The service and all the staff we spoke with felt proud that they made the time to care and to listen to any concerns. Relationships between staff and patients and their relatives highly valued by staff and promoted by managers.
- There was a strong, visible person-centred culture. We observed staff were compassionate and considerate of sensitive issues and held private conversations away from others. When patient or a relative were distressed they took time to comfort them and ensure they received appropriate support. They encouraged them to talk and listened to their concerns. People's emotional and social needs were seen as being as important as their physical needs.
- We reviewed 28 patient feedback cards, all of which contained positive comments. The comments included, 'Everything about this department is indescribable. The staff put my mind at ease,' 'I feel cared for and reassured at all times,' 'all staff incredibly caring and treat me with warmth and great respect. It's like coming home' and 'I have received excellent care from all staff from the consultant, doctors, nurses and admin staff.'
- All day care pods had curtains, which were pulled across to provide a level of visual privacy, although all conversations could still be heard. Staff told us they would use a private room for when confidential conversations needed to take place.
- The radiotherapy department used their own satisfaction survey. This was given to patients either the day before, or on the day that treatment finished. The results from the survey from October 2016 to December 2016 showed 100% of patients rated the service as excellent. The results were taken from a response rate of 77%.

Understanding and involvement of patients and those close to them

- Patients and those close to them were active partners in their care. Patients fully understood their care and treatment and were involved in making decisions. One patient told us of the options they were given as regards the treatment and another told us they were able to choose the start date of their treatment to fit with other personal plans.
- The patients we spoke with were able to describe who to contact if they were worried about their condition after they had left the day unit. They told us their individual preferences and needs were always reflected in how care was delivered.
- The CNS staff told us they acted as the patient's key worker. They went through the information leaflets with the patients and were able to answer any questions.
- All the patients we spoke with felt well informed about their care. One patient said, "I know all about my care plan", and another said, "I was given two different ways of treatment and I went towards my preferred option based on my own research."
- Staff supported patients and their relatives prior to, during and after their appointment. They accessed specialist support if needed and care was tailored to

each individual, dependent on their preferences. There was no restrictions on relatives visiting times. Relatives told us they felt free to stay as long as they wanted to and staff were respectful on their needs.

Emotional support

- Patients told us staff were approachable and had time to explain things. One patient told us, "the staff always go over and beyond their duty so that I feel supported."
- We observed and heard staff speaking with patients in a kind and caring manner. We also observed staff giving reassurance to patients both over the telephone and in person.
- The CNS staff told us they felt offering emotional support was central to their role. They tailored the information to each patient by using their own internal resources and by accessing anything relevant from specific charities. Staff recognised that people needed to have access to and links with their relatives and any other support networks and they supported people to do this. Patients' emotional and social needs were seen as being as important as their physical needs.
- Complementary therapies such as reflexology and massage services were offered to every patient. Patient feedback was consistently positive about the complimentary services provided. One patient said it was a "hugely positive association with chemo", another patient commented the service was "a real treat during a period when you most need and appreciate it."
- We looked at the complementary therapies survey and saw that out of the 42 patients completing the survey in 2016, 85% found the service very good and 15% found it good. There were no negative comments resulting from the survey. One comment said, 'all the staff are very friendly and dedicated to the job they have to do and always supportive to the patients.'
- We saw relatives were able to accompany patients unrestricted into consultation rooms and into the day care 'pods' to provide patients with emotional support during their treatment. All relatives we spoke to felt free to visit the service and said staff were very welcoming.
- Staff told us a quiet clinic room would be made available for breaking bad news if required. One staff member told us that although they had not been given specific training on breaking bad news, they knew they could always ask for advice and get support from other staff members such as the CNS team. Staff also told us the consultants would prepare the team in advance if any bad news that would adversely affect the patient's future was to be given.
- Consultants felt the team had the skills to deal with the immediate distress if families became distressed following bad news. They would access additional psychological support from a counsellor if appropriate.

Are outpatients and diagnostic imaging services responsive?

Outstanding ☆

Service planning and delivery to meet the needs of local people

- The outpatient, day care and radiotherapy services were available to meet the needs of the client group. We heard examples of how service planning was informed by, and tailored to patient's feedback and views. This level of planning was in line with the recommended guidance (NICE QS15 Statement 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their ability to access services and their coexisting conditions). Staff told us patients home location was always considered before booking an appointment time, to take account of travel arrangements. One staff member gave us an example of a patient with a phobia of lifts and how they would be met on the ground floor and either accompanied up the stairs or in the lift, giving extra support**.**
- The joint venture with the host NHS trust was robust and strong collaboration was evident throughout the inspection. There were service level agreements in place for pathology, twenty four hours a day, seven days a week, for staffing cover, maintenance and other key areas.
- The environment was appropriate and patient-centred, with comfortable seating, refreshments and suitable toilets. There was a visitor's room on the same floor, which was available for families and carers to use to rest and make refreshments whilst the patient was undergoing (sometimes lengthy) treatment.

Outpatients and diagnostic imaging

- All patients treated within the day care unit were given an 'out of hours' alert card and information. The cards had details of when to seek help, who to contact, information about their condition and the relevant telephone numbers. If the patient was over an hour's drive from the unit, they were able to use this card in their local accident and emergency department to reduce the delay of managing potential sepsis.
- The hospital offered responsive on site phlebotomy, pharmacy and radiotherapy services.
- The outpatient and radiotherapy service flexed capacity and staffing to meet the demand on the service. Evening appointments were offered to give additional choice and convenience to those who worked, or had other commitments.
- The international team were available from 9am to5pm, Monday to Friday. Staff told us they could offer different appointment times if the patient requested them. There was on call cover twenty four hours a day, seven days a week via an emergency number. A wide range of Arabic forms and information had been developed as a result of the service.

Access and flow

- People were able to access outpatient services and radiotherapy at a time that was convenient for them. All the patients we spoke with found it easy to arrange an appointment and many told us the service was very accommodating. One patient told us the chemotherapy staff were aware that they lived a distance away, and therefore would try and offer an appointment that met with convenient travel times.
- The service did not need to record waiting times (as required by NHS England) as this requirement applies to NHS funded patients only. However, administration staff told us that patients were booked within two weeks and always sooner if urgent. All the patients we spoke with told us it was easy to book a convenient appointment. One patient said, "the appointments are well facilitated around your family schedule". We were shown some of the patient referrals by the administration team and saw the appointment for chemotherapy treatment following an outpatient consultation was within two weeks. Urgent referrals were seen within one week. The administration staff told us they would always try their best to accommodate every patient's needs. They also told us some urgent treatments were authorised by the consultants prior to any insurance company agreement to ensure there was no delays in the treatment.
- Waiting times to radiotherapy treatment were recorded on the patient tracking system. The average waiting time for radiotherapy was less than two weeks.
- Referrals into the service were received via fax and email from GPs and other hospital consultants. All referrals were forwarded to the consultants for vetting before an appointment was made. All referrals were from private patients and therefore, the administration staff also worked closely with the insurance companies to ensure timely payment for the treatment costs.
- All report letters were typed by the secretaries and a copy kept on the electronic system and within the patient's notes. Staff told us the introduction of a new digital dictation system had improved efficiency of this service.
- GPs and consultants could refer patients electronically via email or to a dedicated fax number. The booking staff would confirm the date and time of the appointment with the patient and send a follow-up letter and map for directions.
- The appointments did not over-run during our inspection. We observed good communication between the reception and nursing staff to ensure the service ran smoothly.
- The CNS staff told us they had identified a theme from the incident reporting, relating to the discharge process. A new process was put in place and patients were now called 24 hours after discharge from the service to ensure a follow-up appointment had been made. All relevant staff were included on an email distribution list to improve communication around the discharge process.
- Reception staff told us that any patients who did not attend (DNA) an appointment, were followed up by a phone call from the nursing staff to rearrange an alternative date. Staff told us that patients rarely failed to attend.

Meeting people's individual needs

Outstanding ☆

Outpatients and diagnostic imaging

- Staff told us interpreting services were available for patients attending outpatient or radiotherapy appointments and that they could also use a dedicated language line service.
- Other supportive services available to patients included cultural support, psychology and counselling, complementary therapies, occupational therapy, physiotherapy and a dietetic advice.
- We spoke with staff in the catering team and they told us they catered for cultural and religious needs and other patient preferences and clinically led requirements such as halal and pureed foods.
- During our inspection, we visited the phlebotomy room. Patients could have their bloods taken on the same day as the appointment and staff were trained to do this.
- Reasonable adjustments were made so that disabled patients could access and use the services. A lift was in use to access the various floors of the cancer centre and also in the radiotherapy department.
- Staff told us patients with bariatric needs could be accommodated and specialist equipment ordered if required.
- Staff were able to support patients who had different learning abilities. They gave an example of a young person with Down's syndrome who needed long term treatment. The staff accessed support from a variety of sources, such as the disability CNS from within the host trust and the activities co-ordinator from a cancer charity. We observed one patient praying during their treatment. One staff member discreetly pulled the curtain across to offer them further privacy. They told us they routinely accommodated patient wishes to pray either in the day care 'pod' or in a private room.
- A range of literature and health education leaflets were available and given to each patient. Some of these were available in other languages and could also be translated if required.

Learning from complaints and concerns

- There was an active review of complaints and concerns, as well as how these were managed and responded to. Complaints were handled in line with the hospital policy. We looked at the complaints log from June 2016 to November 2016, where a total of 10 complaints had been recorded. There were no complaints directly relating to the outpatient services. There was one complaint regarding radiotherapy treatment and one regarding a pharmacy process. We found these had been investigated and handled in a timely manner and the patients were satisfied with actions taken and the outcome. The targets set for responding to complaints were being met.
- Senior staff described an open and honest culture and a willingness to accept responsibility for any shortcomings leading to complaints.
- There was a robust system for capturing and learning from complaints. The senior management team were well informed about any complaints and changes were fed back through the heads of departments to frontline staff. Key themes of complaints were discussed at team meetings and we looked at the minutes to confirm this.
- None of the patients we spoke to would have considered raising a complaint but were aware of the process to do so.

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

Leadership and culture of service

- Outpatients department was managed by the matron, who reported to the clinical services manager (CSM). The CSM was responsible for managing all junior doctors and then reported directly to the hospital's chief operating officer (COO) who was also the registered manager for this service.
- The matron and CSM formed part of the hospital's clinical management team, which included the leads for governance and risk as well as the MAC chair and clinical director. The clinical management team was overseen by the executive management team formed of the CEO, COO and chief finance officer.
- Staff spoke highly of the managers of their service and of the specialist nurses. The managers held regular unit meetings where information was exchanged.

- Staff we spoke to were aware of the yearly personal development process with a six monthly review. There was a supportive induction process, so new staff had a clear understanding of what was expected of them and their objectives for the role as soon as they joined the organisation.
- The nursing staff knew the management structure and felt senior managers were approachable, visible and listened to their concerns and ideas. One member of staff told us their manager had an "open door policy". Staff also felt they were encouraged to progress and work towards a promotion within the organisation. A number of staff had been with the organisation for many years and had been promoted. An example of this was an overseas nurse who was recruited as a staff nurse and over the years had progressed to a clinical nurse specialist. They told us they were supported educationally to achieve this by the organisation.
- Radiotherapy staff told us the senior staff were very visible and supportive and took the time to visit them in the adjoining hospital site.
- Many staff told us they loved working in the service and were proud of what they could achieve individually and together. There was a strong sense of teamwork. We saw evidence in both departments that the culture of the services was centred on the needs of the patient. Many staff described how the patients' experience of the service was paramount.

Vision and strategy

- The leadership, management and governance of the service assured the delivery and improvement of high quality person-centre care. The vision and strategy of the service was well known from the CEO to the support worker and all staff were proactive in their approach to delivery of high quality care.
- The service had a clear vision of 'exceptional people, exceptional care.' The senior staff and staff we spoke to during the inspection were clear about the vision and the values that underpinned their work.
- All staff we spoke with from outpatients and radiotherapy were positive about the training academy and felt it was there to support them in their careers and to meet the strategic needs of their services.
- Working in partnership with the host trust, developing quality of care, developing staff and operational excellence were key aims of the strategy of the service and we saw evidence of this being put into practice during our inspection.

Governance, risk management and quality measurement

- There were clear governance arrangements in place which reflected best practice and provided an overarching framework that supported the delivery of the strategy and good quality care.
- Information flowed from the executive team to the staff via the meetings in place. Staff were informed and aware of risks, incidents and mitigation measures. Learning was also shared from across the joint venture network.
- A monthly compliance and risk meeting provided oversight of incidents, duty of candour requirements, complaints and audit trends. This was confirmed in the minutes of these meetings. We also looked at the Quarterly Quality & Safety Review Group meeting minutes from October 2016. This reviewed comparative quality and safety data across the joint venture hospitals. HS at UCH performed well against their peer comparators and had the second highest score out of nine hospitals for patient satisfaction.
- Although care was evidence-based and action plans were constantly reviewed some policies were out of date in radiotherapy. Some of the policies and procedures held on the provider database had gone past their review date and were waiting to be updated. The service lead was aware of the issue and was addressing the need to update the policies in a timely manner. All changes and updates were recorded on an electronic system for staff to sign. We spoke with the senior lead in the department who was aware of the outstanding policies. We were assured that there was no adverse effect on the safety of patients as the information contained within the policies was correct at the time of the inspection and followed best practice guidance. Staff told us they had no problems accessing the system.
- There was evidence of risk assessments being completed with patients and care plans in place to manage the risk. Staff told us there was a process in

place to escalate any risks that could not be resolved locally. The service had a detailed, up-to-date and well organised set of risk assessments and policies for the environment, equipment and consumables used.

- Staff when asked, were aware that risk management and health and safety was everyone's responsibility.
- One member of staff spoke about a drug audit they were involved with and how the results and learning were shared with other colleagues. Another member of staff spoke about an infection control audit they had been involved in.
- We observed a proactive approach to risk and quality improvement. The service maintained a risk register. This identified the impact of the risk, relevant control measures and ongoing ownership and review dates. We did not identify any additional risks that were not on this register during our inspection.
- There was a strong emphasis on radiation protection and monitoring of radiation doses within the radiotherapy department.

Public and staff engagement

- Staff within outpatients and radiotherapy asked all patients to complete a patient experience survey. The survey was also available in Arabic to meet the needs of the largest demographic of international patients. We saw improvements had been made to the radiotherapy waiting area following feedback from patients with the installation of a new coffee machine. Staff showed us how satisfaction rates had improved since the change had been made.
- Staff within outpatients and radiotherapy engaged in regular informal minuted development meetings. They told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues or management.
- CNS staff felt empowered to speak with executive staff to discuss how their strategy could be developed.
- We asked staff if they would recommend the organisation as a place to work. They were all very positive about it as an excellent place to work, delivering high standards of care.
- Feedback given to the inspectors during non-clinical and clinical staff focus groups was overwhelmingly positive. Staff told us they had not been asked to attend but they had wanted to give their own feedback. Comments included, "we all work together to get things done, go above and beyond", the "caring nurses are amazing" and that there was a "very close relationship with whole team."
- Staff told us about the reward and recognition programme and how success was often celebrated with the 'employee of the month' scheme.
- We saw cards and emails from patients and their families giving thanks to the team and the care provided. Staff told us these were shared at team meetings on a regular basis.

Innovation, improvement and sustainability

- The service was engaged in further expansion plans with the host trust to increase the number of inpatient beds and access to the service.
- The CNS team had identified that clinical supervision would be of benefit to their practice. This was acknowledged by the senior managers and a pilot was currently running to give support to staff via a monthly group supervision session from an external clinical supervisor.
- We spoke with one of the consultants who had recently set up a clinic in Kuwait to review patients that had been discharged home there from the clinic.
- One of the CNS team was working on a report to publish data on a new drug used during a research study. The staff member had recently presented the findings at a conference in India.

Outstanding practice and areas for improvement

Outstanding practice

- There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe.
- There was a comprehensive local audit plan.
- The service had a highly visible, passionately engaged senior leadership team. Senior leaders actively encouraged openness and transparency.
- Treatment was always consultant led and used evidence based best practice.
- We observed excellent multidisciplinary team working (MDT) between the nursing, medical and support staff on the unit.
- Without exception, patients told us they were treated with kindness, dignity, respect and compassion. Staff were well motivated. They consistently considered peoples' personal, cultural, social and religious needs and delivered kind and compassionate care. We observed that patients' privacy and dignity was maintained at all times.

Areas for improvement

Action the provider SHOULD take to improve

To ensure patients outcomes are recorded and reported fully in a way that allows meaningful monitoring and benchmarking.

To ensure all medical notes are clearly signed by the doctor with their name printed.

To investigate causes and address high nursing staff turnover.

To ensure fluid charts are always fully completed.

To ensure policies in the radiotherapy department are updated and to establish an effective oversight system to monitor policy and procedures updates.