

The Clatterbridge Cancer Centre NHS Foundation Trust The Clatterbridge Cancer Centre Quality Report

The Clatterbridge Cancer Centre Clatterbridge Road Wirral Merseyside CH63 4JY Tel: 0151 556 5000 Website: www.clatterbridgecc.nhs.uk/

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Outstanding	☆
Medical care	Good	
End of life care	Good	
Outpatients and diagnostic imaging	Requires improvement	
Chemotherapy	Outstanding	\Diamond
Radiotherapy	Outstanding	☆

Letter from the Chief Inspector of Hospitals

The Clatterbridge Cancer Centre is one of the biggest cancer centres in the country and treats patients from across Merseyside, Lancashire, Cheshire, the Isle of Man and North Wales. The trust also provides specialist care and treatment to patients from all over the United Kingdom.

The trust completed the year with an income and expenditure surplus of £56.5 m. However, the trust will be moving to a new site in the centre of Liverpool in 2018, and £49m funding will be reinvested into the cost of the building of the new hospital. The new hospital will make treatment more accessible for those who live in the more deprived areas of Merseyside and the surrounding areas. Some services will remain at the Clatterbridge site including the proton service for eyes.

Oncology services are provided at the hospital there are 74 inpatient beds over three inpatient wards at the hospital and a four bedded young peoples' unit that was found on Mersey Ward. They had a total of 3,760 admissions between April 2015 and March 2016 and had a low number of deaths during the same period (74).

Chemotherapy services are provided by the trusts Systematic Anti-Cancer Therapy (SACT) Service at the Clatterbridge Cancer Centre and at eight peripheral satellite clinics at a range of locations, which include acute general hospitals, primary care centres and other sites managed by the trust. The service also provides certain types of chemotherapy in patient's homes. This service is provided by staff employed and trained by the Clatterbridge Cancer Centre. The adult day-case Delamere chemotherapy unit is open Monday to Friday between the hours of 8.30am and 6.30pm. Between April 2015 and April 2016, the unit delivered 46,974 doses of chemotherapy. Of these 19,979 were delivered at the Clatterbridge Cancer Centre, 26,247 were delivered in the outreach sites and 748 of these doses were delivered in patient's homes.

There are seven linear accelerators for the delivery of radiotherapy treatment at the Clatterbridge site and there is a radiographer led service from a purpose built unit in Aintree with three linear accelerators. The trust delivered 97,926 radiotherapy treatments in the period April 2015 to March 2016. There is a brachytherapy treatment known as Papillon which can provide an alternative to surgery for some rectal cancers. There is a proton beam therapy service for the treatment of cancers of the eye that treats patients from all over the country and from abroad. The low energy proton beam therapy unit is the only one in the country.

A range of outpatient cancer services are provided by the trust and a number of outpatient appointments are also offered in satellite clinics at hospitals throughout Cheshire, Merseyside and the Isle of Man. They offer a combination of consultant and nurse-led clinics including clinical and medical oncology and phlebotomy. A number of therapy led appointments are provided including physiotherapy, speech and language therapy and occupational therapy. There were 99,394 outpatient appointments offered across the trust between July 2015 and April 2016 with 43,318 offered at Clatterbridge Cancer Centre, Wirral.

The diagnostic imaging department consists of two direct radiography (DR) rooms (one of which includes a orthopantomogram (OPT) machine), one computed tomography (CT) scanner, one gamma camera, one positron emission tomography–computed tomography (PET CT) scanner, two magnetic resonance imaging (MRI) scanners, and ultrasound.

End of life services were provided and led by a team of specialist palliative care nurses and a consultant in palliative care medicine, who provided direct care and treatment to patients and supported staff throughout the hospital.

We visited the Clatterbridge Cancer Centre and the Aintree Radiotherapy site as part of our announced inspection during 7 to 9 June 2016. We also carried out an unannounced inspection on 21 June 2016. During this inspection, the team inspected the following core services:

- Medical care services (Oncology)
- End of life
- Outpatients and diagnostic services
- Chemotherapy
- Radiotherapy

Overall, we rated The Clatterbridge Cancer Centre NHS Foundation Trust as outstanding. We have judged the service as 'good' for safe, effective and responsive. We rated the domains of caring and well-led as 'Outstanding'.

Our key findings were as follows;

Vision and strategy

- There was a clear trust strategy plan for 2014 to 2019 which had been refreshed in February 2016. This was supported by the establishment of a Transformation Programme Office to support the delivery of the transformation agenda. The plan was linked to other external plans including the Five Year Forward View (5YFV) [Published October 2014]; the 2016/17 planning guidance (particularly the opportunities provided by the requirement for the development of health economy sustainability and transformation plans (STPs) that cover the same planning period). Published December 2015 and the Report of the cancer taskforce (Achieving World Class Outcomes: a strategy for England 2015-2020)
- All services had local plans which linked to the trust strategy.

Leadership and Management

- The hospital was led and managed by a visible executive team. This team were well known to staff, and staff spoke highly of the commitment by leaders to continually improve services putting patients and people close to them at the centre of decision making.
- There was effective teamwork and clearly visible leadership within the services and decision-making was patient centred and clinician led.
- Leaders understood the challenges to good quality care and identified actions to address them.
- Staff felt involved in decision making, and felt that they were able to influence the vision and strategy of the organisation.
- The NHS staff survey 2015 showed the trust performed better than the national average for 12 indicators and as expected in a further seven. The overall staff engagement score for the trust was 3.98, which was in line with the national average score of 3.94 for specialist acute trusts.

Culture

- The trust had "the Clatterbridge Culture Programme" in place which was a five year strategy to create a culture in which positive behaviours are experiences consistently throughout the organisation. This contained a culture recipe and clear measurement of each of the culture dimensions.
- All the staff we spoke with were proud, highly motivated and spoke positively about the care they delivered. Staff told us there was a friendly and open culture. They told us they received regular feedback to aid future learning and that they were supported with their training needs by their managers.
- All leaders appeared to be competent, knowledgeable and experienced to lead their teams and understood the challenges to good quality care and what was needed to address those challenges. Leaders strived to deliver and motivate staff to succeed and to continue to improve. Managers sought to improve the workforce culture to engage with staff to achieve advances in care and quality.

- We saw that a very positive and supportive culture across all wards and departments. Staff were very proud of their hospital and the work they did. They were enthusiastic and passionate about the care they provided and the achievements they have accomplished. There was a tangible sense of willingness to go the extra mile and do the very best for their patients.
- There was an open and honest culture within the organisation and staff were candid about the challenges they faced.
- Staff morale was reported to be good although in outpatients the amount change the department had experienced in a short period of time had affected morale.

Governance and risk management

- We found all policies to be clear, accessible and up to date.
- The trust had been awarded significant assurance by Mersey Internal Audit for the last two years regarding information governance (IG). The IG Toolkit was reported as 80% compliant for 2015/16.
- Clinical governance managers were integrated in to directorates, attending and reporting to directorate meetings and providing leadership with root cause analyses.
- Local risk registers were seen to be relevant and up to date; however in oncology the process required strengthening. The use of monitoring including dashboards and audits was seen in all areas.

Cleanliness and Infection control

- Clinical areas at the point of care were visibly clean.
- The trust had infection control and prevention policies in place, which were accessible to staff and staff were knowledgeable on preventing infection and minimising risks to patients, visitors and staff.
- The local Infection Control Committee met regularly and covered all expected areas.
- In April 2016 the committee reported that the C.Diff objective for the year remained at one case. There had been no MRSA bacteraemia infections.
- Staff were observed to comply to bare below the elbow standards and hand washing procedures were adhered to. The use of personal protective equipment was of a good standard.

Staffing

- Medical, nursing and radiographer staffing was good and in line with the expectations at a specialist trust. Staff told us that they felt well-staffed and they felt that they had enough time to care for patients and medical response was timely when required.
- Nurse staffing levels were based on an acuity tool. Staff sickness and turnover rates were as expected. Staff told us that they felt well-staffed and they felt that they had enough time to care for patients. Staff vacancies were noted on the risk registers and actions had been identified to mitigate these risks. There was a reliance on temporary staffing on some of the wards but there was a buddy system in place to make sure they were well supported.
- Concerns were found around staffing in the diagnostic imaging service.

Mortality rates/ Patient outcomes

- As a specialist cancer trust, it is inevitable that many patients with advanced cancer spend their final weeks as patients of Clatterbridge Cancer Centre, and whilst acknowledging the desire of the most terminally ill patient to die at home, for some, symptom control issues or social difficulties mean that their end-of-life care is delivered within a hospital.
- Between April 2014 and March 2015 there were 50 deaths at the centre.
- Accordingly a significant number of deaths occurring within the trust were "expected". The Trust Management Group
 reviewed the 99 inpatient deaths occurring between April 2014 and January 2016, only 5 were deemed to be
 unexpected. The palliative care team had significant input into the management of in-patients with advanced
 disease, and often patients had been on the Amber Care Bundle or an end-of-life pathway in the days or weeks prior
 to their death.

4 The Clatterbridge Cancer Centre Quality Report 01/02/2017

- The service participated in the National Chemotherapy Multi-Disciplinary Team (MDT) Peer Review (2014) being compliant with 35 out of 36 standards and scoring 97.6% overall. The service scored 100% overall compliance with the 19 standards for intrathecal chemotherapy in the National Chemotherapy MDT Peer Review (2014).
- Data contributions to the National Care of the Dying audit showed that the service had performed better than others nationally in the ten key clinical performance indicators.

We saw several areas of outstanding practice including:

In the End of Life Service;

- The service had developed a simulation based training programme to develop the skills and knowledge of staff throughout the hospital. This involved simulating difficult situations so that staff developed their confidence when dealing with patients and relatives at the end of life.
- All staff were committed to facilitating the requests of patients at the end of life. For example, there had been a number of weddings organised within a short period of time at the request of patients. Several staff were involved in facilitating these.
- The service had responded to NICE guidance by developing a day after death service which met the needs of the bereaved in that a number of risk assessments were undertaken to ensure their welfare.
- The SPC consultant was involved in a number of projects. For example, the serious illness programme UK was being piloted collaboratively with one organisation from the United States and had been designed in response to services recognising the challenging situations that clinicians faced when dealing with patients and relatives at the end of life.

In the Outpatients and Diagnostics service;

• Individual needs of patients were identified through completion of a Holistic Needs Assessment at varying times during treatment and surveillance. Following completion a care plan was formulated to summarise any concerns and identify actions to address them.

In the Radiotherapy service;

- The development of the advanced practice radiographer posts that enabled consultants and registrars to do the more complex work.
- The uses of skill mix across the department for staff at all levels including health care assistants
- The continuing development of the Papillon service as an alternative to radical surgery.
- The proton beam service for the treatment of eye cancers and its continuing development and training of staff from other centres.
- Radiographers able to prescribe medicines for head and neck cancer patients to alleviate their pain.
- The development and use of the vac bags to help to immobilise patients during treatment and the making of individual head rests to make patients more comfortable.

In the Chemotherapy service;

- The innovative introduction of the rapid chair initiative in the Delamere unit had improved the experience and waiting times for patients receiving shorter treatments.
- The introduction of the Adjuvant Zoledronatec service was innovative and market leading. The introduction of this service meant that patients with breast cancer were receiving the very latest evidence based treatment to reduce their risk of death and reoccurrence.
- The Chemotherapy at Home project was outstanding and provided patients with treatment in their own homes. This service embodied the overall trust and service vision of providing the best cancer care to their patients.
- The positivity and compassion shown by staff and reflected in the feedback from patients was outstanding. It was clear that all levels of staff continuously strived to provide outstanding care to their patients.

- The interaction and utilisation of the Maggie's Merseyside charity was excellent. It meant that patients could access all the advice, support and treatment in one place at one time.
- The support offered to patients throughout their treatment was outstanding. This included the implementation of the end of treatment bell, the PAT therapy dog and handler, massages and relaxation techniques for patients and the program of activities provided in the Maggie's centre. All of which contributed to patients receiving an excellent level of emotional and practical support.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Improve the staffing within the diagnostic imaging service.
- Ensure that concerns were raised regarding the protection documentation (as required by the Ionising Radiation Regulations 1999 (IRR) and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R)) which was overdue for review or did not reflect current clinical practise such as a risk assessment from 2013, and local rules from 2014 are addressed.

Professor Sir Mike Richards Chief Inspector of Hospitals

Our judgements about each of the main services

Service Medical care

Rating

Good

ng Why have we given this rating?

We rated oncology services as good overall because;

- Feedback from patients and those close to them was consistently positive about the way staff treated them. Staff went the extra mile to provide care and support. There was a strong person-centred approach to providing care. Relationships between people who used services and staff were caring, supportive and promoted people's dignity.
- Services provided by the trust reflected people's individual needs and preferences and continuity of care for patients was central for staff. There was a proactive approach to understanding the needs of different groups of people including vulnerable patients and reasonable adjustments were made.
- The hospital had implemented a number of schemes to help meet people's individual needs, such a falling leaf symbol to indicate that a patient was frail or elderly. This helped alert staff to people's needs.
- Facilities and premises were appropriate for the services delivered and were well resourced.
- Incidents were reported by staff through effective systems. Lessons were learnt and investigation findings and improvements made were fed back to staff. There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse. The hospital was clean and staff followed good hygiene practices.
- Staffing levels were largely good and were reviewed regularly to ensure that there was enough staff with the correct skills to keep people safe. Any staff shortages were responded to and there was a buddy system in place to ensure temporary staff were supported.

- Best practice guidance in relation to care and treatment was usually followed and medical services participated in national and local audits. Action plans were in place if standards were not being met.
- People were supported to raise a concern or a complaint. Lessons were learnt and improvements made from complaint investigations. Oncology services captured views of people who used the services with changes made following feedback. The friends and family test showed that people would recommend the hospital to friends or a relative.
- There were governance structures in place which included a risk register. All staff knew the trust vision and behavioural framework. They felt supported and said morale was good. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

However,

- Mandatory training levels in some key areas such as life support and infection control were low and overall compliance was below the trust target.
- Records were not always kept secure and some patient assessments were not always fully completed.
- The hospital had not implemented recognised schemes to help meet the individual needs of patients living with dementia. The dementia strategy was not fully embedded across the wards.
- Actions on the register did not have a timeframe identified. This meant it was unclear if all risks were managed in a timely way to lower the risk. Staff were not always recording incidents in a timely way due to the system being paper based.

We rated end of life care services as 'good ' overall because;

End of life care

Good

- End of life services were led by a dedicated specialist palliative care consultant and a team of specialist nurses who were dedicated to providing the best possible care and treatment.
- The SPC team had developed a clear vision and strategy which was supported by an end of life care work programme which were aimed at improving the current services provided further.
- The SPC consultant was involved in a number of different projects to improve end of life services not only at the trust, but also nationally.
- We found that the numbers of nursing staff on inpatient wards were adequate to provide care and treatment to patients at the end of life.
- We found that both the SPC team and general staff on the inpatient wards were keen to tell us how proud they were of the service that they provided. All staff were committed to high quality, compassionate care.
- End of life services had been developed and were delivered in line with current best practice guidance. The service had responded to the Liverpool care pathway being withdrawn by implementing an individual communication record which had been designed to meet individual needs of patients at the end of life.
- The service made regular contributions to the National Care of the Dying Audit and the most up to date records from January 2016 showed that the service performed better than other services nationally in all ten clinical indicators.
- We saw some positive examples of multi-disciplinary team working. End of life services were everybody's responsibility and the SPC team provided a good level of support to nursing and medical staff on the inpatient wards.

However,

- The SPC team were not currently able to provide a seven day service. There were plans in place to introduce this in September 2016.
- End of life care training had been included as part of the mandatory training programme for all staff. However, there was currently a low level of compliance with this.
- The service did not currently use advanced care planning and were not part of the gold standard framework accreditation scheme.
- There was limited evidence of incidents and complaints being discussed in governance meetings which meant that it was unclear how lessons were being learnt and improvements were being made.
- The trust had a service level agreement in place with another hospital for the provision of on-site mortuary services. However, we found that there was no assurance that this was being monitored appropriately through key performance indicators.

Outpatients and diagnostic imaging

Requires improvement



We rated the outpatient and diagnostics service requires improvement because:

- Radiation protection documentation (as required by the Ionising Radiation Regulations 1999 (IRR) and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R)) was overdue for review or did not reflect current clinical practise such as a risk assessment from 2013, and local rules from 2014.
- Staff in diagnostic imaging found it difficult to locate key documents and were not able to demonstrate knowledge or understanding of the contents. Staff found it difficult to access the document control system where these documents were held, and the paper copies in the department were out of date.

- Documentation showed that emergency resuscitation equipment was not consistently checked on the CREST (Cancer Rehabilitation and Support Team) corridor.
- Compliance rates for mandatory and statutory training did not meet the trust targets in a number of subjects.
- Not all staff reported receiving Mental Capacity Act training.
- The outpatient reception and waiting area did not allow privacy and confidentiality when booking in or when height and weight measurements were taken.
- The outpatient waiting area had a limited amount of space and was cramped when clinics were busy.
- There was no defined outpatient therapy service and at the time of our inspection and the outpatient physiotherapy service was restricted due to the prioritisation of inpatient care.
- Staff within the outpatient department reported that morale was not good due to the amount change the department had experienced in a short time period of time and they had not felt involved or consulted with effectively.

However,

- Staff knew how to report incidents and received feedback, lessons learnt were disseminated in monthly team meetings and in the trust wide Team Brief.
- All areas were visibly clean and staff adhered to "bare below the elbow " guidelines.
- Safety testing for equipment was in use across the outpatients department and emergency resuscitation equipment was in place. Medicines were stored securely in a locked cupboard.

- Availability of medical records for outpatients clinic was audited which showed 99% of medical records were available for outpatient clinics.
- Care and treatment within the outpatient department was delivered in line with evidence-based practice and staff provided examples of specific guidance and pathways used.
- Staff meetings took place monthly in outpatients to share information and promote shared learning and an audit programme was in progress assessing compliance in relation to a number of activities.
- Competency assessments were in place for staff in the outpatients department and opportunities were available for continuing professional development including support to attend courses and conferences.
- The outpatients department was staffed by a range of professionals working together as a multi-disciplinary team to provide a comprehensive service to patients and Specialist Nurses were in post in a wide range of specialities.
- Patients were given additional time during consultations particularly when receiving difficult news.
- Between December 2015 and April 2016 results from the NHS Friends and Family Test showed the percentage of patients that would recommend the outpatient service ranged from 94% to 98%.
- Patients and their families were involved in their treatment and care planning.
- Patients received written information regarding their appointment and condition. Car parking, newspapers and refreshments were available free of charge to all patients attending the outpatients department.
- Patients' individual concerns were identified through completion of a Holistic Needs Assessment at varying times during treatment and surveillance and a care plan written to address any identified needs.

		 Staff described how people in vulnerable circumstances were accommodated in the department and provided examples of support provided using a multi-disciplinary approach. Patients were provided with additional time during their appointment if required and a 24 hour advice line was available for patients with concerns or who felt unwell. The trust consistently met the national standard for referral to treatment times for incomplete pathways and for cancer patients to receive first definitive treatment within 31 days of diagnosis. The trust DNA rate was consistently lower than the England average. Chemotherapy Directorate Strategic and Operational Group meetings took place monthly to discuss risks, performance and key issues and quality and performance were monitored through a strategic dashboard. Staff felt supported by their local managers and said the executive team were visible. Daily safety huddles and monthly team meetings took place to ensure staff received information and feedback.
Chemotherapy	Outstanding	 We rated the chemotherapy service outstanding because: The service had a clear focus on safety and patient centred care. Safety was a high priority throughout the service and there was routine measurement and monitoring of safety and performance within the service. Risks were appropriately and identified. We found that the care delivered to patients was evidence-based and in line with key documents such as National Institute of Health and Care Excellence guidance. There was routine monitoring of patient outcomes of care and treatment, and patient feedback was actively sought on a regular basis. The training for staff involved with the delivery of chemotherapy was appropriate to their role and provided on a regular basis.

Staff appraisals were completed. All teams within the service worked effectively and engaged with other professionals to ensure patients received the required level of care and support. Staff spoke very positively about the support they were given by leaders and management. Managers within the service lead by example and staff told us they were inspirational.

- Staff treated patients as partners in their care and treatment and empowered them to make choices about their treatment plan and direction. Staff were passionate and committed to providing outstanding care. Staff were observed providing care to patients with kindness, compassion and dignity. Staff at all levels routinely went the extra mile to provide outstanding care to patients.
- Individual needs were identified and responded to appropriately. The service also provided an innovative and comprehensive chemotherapy program in patients own homes and were considering offering this service in workplaces. Psychological support, counselling and complementary services were all provided free of charge for patients and their relatives.
- The service had introduced an innovative 'rapid chair' initiative in response to issues with patients experiencing delays. This meant that patients who were receiving short periods of chemotherapy did not experience delays. This service was introduced in direct response to patient feedback.
- The service had a comprehensive strategy and business plan, which took into account sustainability for the future. The service was responsive to patients' needs and fully took into account the needs of the population they served. The service had adapted to meet the needs of the patients using their services and was actively engaging with the public regularly to ensure that they provided services that met their needs. Patients could access treatment and care in a timely way. All

patients we spoke with told us that they had experienced no delays in accessing chemotherapy and eight out twelve patients told us they were surprised at how quickly their treatment had been commenced.

• All patients we spoke with told us that the care they received from the service exceeded their expectation.

Radiotherapy

Outstanding

We rated the radiotherapy service outstanding because:

- Services were safe and there was a good and open culture of incident reporting. Lessons were learned and the duty of candour was applied appropriately.
- Patients commented on the cleanliness of the departments and audits were carried out to ensure that equipment was clean. There were infection control processes in place which were also audited.
- The equipment and techniques used for radiotherapy were some of the most advanced in the country.
- There was a comprehensive audit system in place and a culture of continuous learning, development and improvement across radiotherapy and medical physics.
- Staff development was good for all grades of staff and radiographers were taking on new roles that enabled consultants to undertake more complex work.
- Patients were extremely complementary about the service and there were good interactions between staff and patients. Patients and their carers were supported. There was a self- help group for patients who had completed their treatment at the Aintree site and a wide range of complementary therapies were available for patients.
- Patients were given a full schedule of appointments at their first appointment.
- The governance of the department was very effective and the department had participated in an external quality management standard and had done for several years.

- Leadership was robust, which contributed to a culture of improvement and a focus on improving short and long term outcomes for patients.
- The department had consistently achieved their referral for treatment targets though some patients waited more than 31 days to start their treatment. The department cancelled very few clinics.



The Clatterbridge Cancer Centre

Detailed findings

Services we looked at Medical care ; End of life care; Outpatients and diagnostic imaging; Chemotherapy and Radiotherapy.

Contents

Detailed findings from this inspection	Page
Background to The Clatterbridge Cancer Centre	18
Our inspection team	19
How we carried out this inspection	19
Facts and data about The Clatterbridge Cancer Centre	20
Our ratings for this hospital	21
Action we have told the provider to take	119

Background to The Clatterbridge Cancer Centre

The Clatterbridge Cancer Centre is one of the biggest cancer centres in the country and treats patients from across Merseyside, Lancashire, Cheshire, the Isle of Man and North Wales.

The trust will be moving to a new site in the centre of Liverpool in 2018, this will make treatment more accessible for those who live in the more deprived areas of Merseyside and the surrounding areas. Some services will remain at the Clatterbridge site including the proton service for eyes.

The oncology service at the hospital provides care and treatment for patients who require non-surgical oncology treatments as an inpatient on its main site on the Wirral. The trust provides specialist care and treatment to patients from all over the United Kingdom and overseas, as well as their catchment areas of Merseyside and Cheshire. There are 74 inpatient beds at the hospital and they had a total of 3,760 admissions between April 2015 and March 2016. The wards were part of the integrated care directorate.

Chemotherapy services are provided by The Clatterbridge Cancer Centre's Systematic Anti-Cancer Therapy (SACT) Service. This service is provided at the Clatterbridge Cancer Centre and at eight peripheral satellite clinics at a range of locations, which include acute general hospitals, primary care centres and other sites managed by the trust. The service also provides certain types of chemotherapy in patient's homes. This service is provided by staff employed and trained by the Clatterbridge Cancer Centre. The adult day-case Delamere chemotherapy unit is located at the Clatterbridge Cancer Centre. This unit is open Monday to Friday between the hours of 8.30am and 6.30pm.

Between April 2015 and April 2016, the unit delivered 46,974 doses of chemotherapy. Of these 19,979 were delivered at the Clatterbridge Cancer Centre, 26,247 were delivered in the outreach sites and 748 of these doses were delivered in patient's homes.

There are seven linear accelerators for the delivery of radiotherapy treatment at the Clatterbridge site and there are three at the purpose built unit in Aintree, which is a radiographer led unit. The trust delivered 97,926 radiotherapy treatments in the period April 2015 to March 2016. There is a brachytherapy treatment known as Papillon which can provide an alternative to surgery for some rectal cancers. There is a proton beam therapy service for the treatment of cancers of the eye that treats patients from all over the country and from abroad. The low energy proton beam therapy unit is the only one in the country.

A range of outpatient cancer services are provided by The Clatterbridge Cancer Centre NHS Foundation Trust and a number of outpatient appointments are also offered in satellite clinics at hospitals throughout Cheshire, Merseyside and the Isle of Man.

The Clatterbridge Cancer Centre NHS Foundation Trust offers a combination of consultant and nurse-led clinics

including clinical and medical oncology and phlebotomy. A number of therapy led appointments are provided including physiotherapy, speech and language therapy and occupational therapy.

Data from the trust showed there were 99,394 outpatient appointments offered across the trust between July 2015 and April 2016 with 43,318 offered at Clatterbridge Cancer Centre, Wirral.

The diagnostic imaging department sits in the Radiation Service Directorate within the Trust. The department currently consists of two direct radiography (DR) rooms (one of which includes a orthopantomogram (OPT) machine), one computed tomography (CT) scanner, one gamma camera, one positron emission tomography–computed tomography (PET CT) scanner, two magnetic resonance imaging (MRI) scanners, and ultrasound. Clatterbridge Cancer Centre provides specialist care and treatment to patients across the North West, North Wales and the Isle of Man. The hospital had 3,760 admissions between April 2015 and March 2016 and had a low number of deaths during the same period (74).

The hospital had three inpatient wards and a total of 74 beds, with a mixture of open plan areas and doored side rooms. There was also a four bedded young peoples' unit that was found on Mersey Ward. There was not a designated ward or area for patients who were at the end of life.

End of life services were provided and led by a team of specialist palliative care nurses and a consultant in palliative care medicine, who provided direct care and treatment to patients and supported staff throughout the hospital.

Our inspection team

Our inspection team was led by: Lorraine Bolam, Care Quality Commission

Chair: Jane Barrett

Inspection Manager : Nicola Kemp, Care Quality Commission

The team included an Inspection manager, 7 CQC inspectors, a radiology CQC specialists, a CQC pharmacist, inspection planner, , a senior analyst and a variety of specialists including :

Clinical Nurse Specialist; 2 Oncology Nurses; 2 Consultants in Clinical Oncology; a Consultant Nurse in Palliative Care; a Macmillan Nurse; a Strategic Lead for Integrated Governance and Organisational Development; a Clinical Governance Manager; a Head of Clinical Quality Assurance; a Clinical Auditor - Safeguarding Adults & Children and an Equality and Diversity specialist.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting the hospital, we reviewed a range of information we held about The Clatterbridge Cancer Centre NHS Foundation Trust and asked other organisations to share what they knew about it. These included the Clinical Commissioning Groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Health watch.

We had stalls in the hospital for people who had experienced care at The Clatterbridge Cancer Centre NHS Foundation Trust to share their experiences with us.

Some people also shared their experiences by email and telephone. The announced inspection of The Clatterbridge Cancer Centre NHS Foundation Trust was from 7 to 9 June 2016.

The inspection team inspected the following core services at The Clatterbridge Cancer Centre NHS Foundation Trust

- Medicine (Oncology)
- Chemotherapy
- Radiotherapy
- Outpatients and Diagnostic Imaging
- End of life care

As part of the inspection, we held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, staff from BME backgrounds, trade union representatives and managers. We also spoke with staff individually as requested. We talked with almost 50 patients and carers and over 120 staff from all the ward areas and outpatients and diagnostic services. We observed how people were being cared for, talked with carers and/or family members, and reviewed over 70 patients' records of personal care and treatment including medication records.

We undertook an unannounced inspection between 2.30pm and 6pm on 21 June 2016 at The Clatterbridge Cancer Centre. We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at The Clatterbridge Cancer Centre NHS Foundation Trust.

Facts and data about The Clatterbridge Cancer Centre

From ten operating sites across Merseyside and Cheshire The Clatterbridge Cancer Centre NHS Foundation Trust treat over 30,000 patients a year, offering pioneering chemotherapy, radiotherapy and proton therapy treatments. specialist cancer care is available to patients from all over the UK and overseas, as well as their catchment areas of Merseyside, Cheshire, North Wales, the Isle of Man and parts of Lancashire.

During 2015/16 they delivered 96,502 outpatient radiotherapy treatments on their 11 linear accelerator machines. Eight of these machines are located at Clatterbridge Cancer Centre - Wirral, whilst the remaining three are located in Clatterbridge Cancer Centre - Aintree.

Clatterbridge Cancer Centre - Aintree, a £17m purpose built centre, helps bring expertise and treatment 'closer to patients' and partnership working with the neighbouring specialist neurological Trust (The Walton Centre) offers cancer patients treatment options previously unavailable in the northwest region.

In 2015/16 they delivered more than 45,000 outpatient chemotherapy treatments and over 1,000 inpatient chemotherapy episodes of care. In addition to the chemotherapy services available at the Delamere Day Case Unit at Clatterbridge Cancer Centre - Wirral, they also deliver chemotherapy treatments at weekly nurse-led clinics in eight district hospitals across Merseyside and Cheshire.

The introduction of Acute Oncology Teams has greatly improved the experience and care of patients admitted to A&E with cancer related illnesses. Their acute oncology specialists operate in seven hospitals across Merseyside and Cheshire. The team brings together expertise from oncology, surgery, emergency and general medicine, diagnosing patients more quickly and reducing treatment delays. 92% of all cancer patients attending A&E are now seen within 24 hours of referral.

Since April 2013 they have been running 'Clatterbridge Private Clinic' - a specialist cancer clinic for private patients offering chemotherapy and radiotherapy treatments. The new facility is managed by The Mater Private in partnership with The Clatterbridge Cancer Centre and offers private patients the choice of receiving high quality treatment in a dedicated clinic without any

impact on NHS services. Income from Clatterbridge Private Clinic is reinvested back into The Clatterbridge Cancer Centre NHS Foundation Trust to support the delivery of cancer care across the region.

The health of people across Liverpool is generally worse than the England average. Deprivation is higher than average and about 32% children live in poverty. Life expectancy for both men and women is lower than the England average. At the time of inspection there were 1080 whole time equivalent (wte) staff, of which 66 were medical staff, 435 were nursing staff, 194 were Allied Health professionals and 385 were other staff disciplines.

Our ratings for this hospital



Our ratings for this hospital are:

Safe	Requires improvement	
Effective	Good	
Caring	Outstanding	公
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

When we refer to oncology service we mean medical services for the hospital. The oncology service at the hospital provides care and treatment for patients who require non-surgical oncology treatments as an inpatient on its main site on the Wirral. The trust provides specialist care and treatment to patients from all over the United Kingdom and overseas, as well as their catchment areas of Merseyside and Cheshire. There are 74 inpatient beds at the hospital and they had a total of 3,760 admissions between April 2015 and March 2016. The wards were part of the integrated care directorate.

We visited Clatterbridge Cancer Centre as part of our announced inspection on 7 to 9 June and as part of our unannounced inspection on 21 June 2016.

As part of the inspection, we visited Mersey ward (emergency admissions and assessments), Sulby ward (planned chemotherapy and radiotherapy treatments), Conway ward (chemotherapy and radiotherapy), the teenage and young adult unit and the triage and assessment service. We reviewed the environment and staffing levels and looked at 23 care records and 10 prescription records. We spoke with six family members, 15 patients and 36 staff of different grades including nurses, doctors, ward managers, physiotherapists, advanced nurse practitioners, healthcare assistants, a housekeeper, admin staff and the senior managers who were responsible for oncology services. We received comments from people who contacted us to tell us about their experience at the trust. We reviewed performance information about the trust. We observed how care and treatment was provided.

Summary of findings

We rated oncology services as good overall with effective, responsive and well-led domains rated as good, requires improvement for safe and 'outstanding' for caring. This was because;

- Feedback from patients and those close to them was consistently positive about the way staff treated them. Staff went the extra mile to provide care and support. There was a strong person-centred approach to providing care. Relationships between people who used services and staff were caring, supportive and promoted people's dignity.
- Services provided by the trust reflected people's individual needs and preferences and continuity of care for patients was central for staff. There was a proactive approach to understanding the needs of different groups of people including vulnerable patients and reasonable adjustments were made.
- The hospital had implemented a number of schemes to help meet people's individual needs, such a falling leaf symbol to indicate that a patient was frail or elderly. This helped alert staff to people's needs.
- Facilities and premises were appropriate for the services delivered and were well resourced,
- Incidents were reported by staff through effective systems. Lessons were learnt and investigation findings and improvements made were fed back to staff. There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse. The hospital was clean and staff followed good hygiene practices.
- Staffing levels were largely good and were reviewed regularly to ensure that there was enough staff with the correct skills to keep people safe. Any staff shortages were responded to and there was a buddy system in place to ensure temporary staff were supported.
- Best practice guidance in relation to care and treatment was usually followed and medical services participated in national and local audits. Action plans were in place if standards were not being met.
- People were supported to raise a concern or a complaint. Lessons were learnt and improvements made from complaint investigations. Oncology

services captured views of people who used the services with changes made following feedback. The friends and family test showed that people would recommend the hospital to friends or a relative.

• There were governance structures in place which included a risk register. All staff knew the trust vision and behavioural framework. They felt supported and said morale was good. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

However,

- Mandatory training levels in some key areas such as life support and infection control were low and overall compliance was below the trust target.
- Records were not always kept secure and some patient assessments were not always fully completed.
- The hospital had not implemented recognised schemes to help meet the individual needs of patients living with dementia. The dementia strategy was not fully embedded across the wards.
- From the information provided by the hospital at the time of the inspection, actions on the risk register did not have a time frame identified. This meant it was unclear if all risks were managed in a timely way to lower the risk. Staff were not always recording incidents in a timely way due to the system being paper based.

Are medical care services safe?

Requires improvement



We rated oncology services as 'Requires Improvement' for Safe because:

- A high proportion of staff we spoke to during the inspection said they did not always report an incident in a timely way due to the current system being paper based and the time it took to complete the incident form.
- Staff attended mandatory training courses but compliance rates were below the trust target in some key subjects such as basic life support and infection control. Senior managers were aware and were reviewing the number of training areas classified as mandatory as the expectation had become undeliverable.
- On the wards there were needles and sharp instruments in unlocked trolleys which meant there was a risk that these were accessible to patients and the public.
- There were medication assessment forms and intentional rounding records that were not always completed. There were patient records which were not always kept secure on one ward.

However,

- Staffing levels on all the wards were largely good. Staff vacancies were noted on the risk register and actions had been identified to mitigate this risk. There was a reliance on temporary staffing on some of the wards but there was a buddy system in place to make sure they were well supported.
- Incidents were reported by staff through effective systems and staff were aware of lessons learnt and that improvements had been made from investigations. There were systems and standard operating procedures in place to keep people safe and staff were aware of how to ensure patients were safeguarded from abuse.
 There were systems in place to manage the safe administration and prescribing of medication. Medication requiring cool storage was appropriately stored in fridges and temperature checks were always completed. Controlled drug checks were always completed on the wards and there was good stock control.

- There were effective systems in place to ensure patient safety was monitored and maintained which included signs of deteriorating health and medical emergencies. Staff responded appropriately to changes in risks to people who used services.
- The hospital was clean and staff followed good hygiene guidance. There was good monitoring of infections and we observed that cleaning schedules were completed as required.
- Incident reporting was a paper based system although an electronic system was being implemented

Incidents

- Staff were familiar with and encouraged to use the trust's policy and procedures for reporting incidents. We spoke with a range of staff across the service that were all aware of how to report incidents. However, there were concerns that as the system was paper based there was a risk that incidents may not have been recorded.
- Some of the staff we spoke to said that they did not always report incidents in a timely way due to the current system in place. The trust was in the process of implementing a new electronic system for recording of incidents which would help ensure that all incidents were captured and analysed.
- In the 2015 staff survey 59% of staff said they had reported an incident that could have harmed patient or staff.
- A root cause analysis tool was used to investigate serious incidents. We saw an action plan was put in place where required to reduce the risk of the incident happening again. Action plans included evidence of feedback and actions for learning which were shared with clinical teams and the wider trust. Between March 2015 and March 2016 integrated care services reported 900 incidents. Of these, 107 were incidents of falls which was the most commonly occurring incident. Actions had been identified to help prevent further incidents. For example reviewing where drip stands were stored on wards and as part of the admission processes patients are informed to use the call bell if they needed assistance.
- Between April 2015 and March 2016 there were six serious incidents reported throughout integrated care

and no never events reported (never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented).

- Senior staff told us general feedback on patient safety information was discussed at ward staff meetings or in staff huddles. On the wards senior staff met with ward staff to look at lessons learnt from incidents.
- Staff told us they received feedback from incidents they had reported via email, though this was sometimes delayed due to the current system. The outcome of investigations was also received from senior staff. Staff were able to describe a change made following an incident. For example, a review of the alcohol pathway and additional training for staff in recognising cognitive impairment for patients who have an alcohol dependency.
- Mortality and morbidity meetings were held every month and themes and trends were discussed. Learning and actions had been identified but it was unclear if the timeframe for actions or the person responsible had been identified. This made it difficult to track progress. These were also discussed and reviewed at the divisional governance committee meeting were learning was shared.
- Senior staff were aware of their responsibilities relating to Duty of Candour legislation and were able to give us examples of when it had been implemented. The trust had a duty of candour process in place to ensure people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence. 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.

Safety thermometer

 The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.

- Safety thermometer information for oncology services showed that between March 2015 and March 2016 there had been 14 pressure ulcers, six falls and 18 CAUTI's which resulted in harm.
- The trust monitored incidents of pressure ulcers and falls through their performance dashboard each month. However from the minutes thatwere reviewed it did not appear that these were fully discussed at every directorate governance meeting.
- Safety thermometer information was prominently displayed on the information boards on all of the wards and units we visited.
- Pressure ulcers were on the risk register. There was an action highlighted to continue to monitor the action plan but no progress or update was recorded on the information received from the trust.

Cleanliness, infection control and hygiene

- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures. There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice, bare below the elbow and using personal protective equipment where appropriate.
- All wards had antibacterial gel dispensers at the entrances and by people's bedside areas. Appropriate signage regarding hand washing for staff and visitors was on display.
- Between April 2015 and February 2016 integrated care services reported two cases of clostridium difficle, no cases of methicillin-resistant staphylococcus aureus (MRSA) or methicillin-susceptible staphylococcus aureus (MSSA).
- Wards used the 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use. Staff we spoke with understood this labelling system.
- All the wards and units we visited were visibly clean and free from odour. We observed that cleaning of the environment was thorough and we saw this being undertaken during our visit.
- Monthly infection control audits were undertaken across all wards which looked at standards and compliance such as the cleanliness of the environment, the implementation of the central venous catheter care bundle and care bundle to prevent surgical site

infection. Between December 2014 and November 2015 all wards scored 100%. Monthly hand hygiene audits were undertaken by staff being observed. Results for all the wards were 100%.

- Trust patient led assessments of the environment (PLACE) in 2015 showed a standard of 98% in the trust for cleanliness which was above the England average.
- Side rooms were used as isolation rooms for patients at increased risk of cross infection. There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room.
- We observed that the disposal of sharps, such as needle sticks followed good practice guidance. Sharps containers were dated and signed on assembly, and the temporary closure was used when sharps containers were not in use.
- Cleaning schedules were in place and the majority had been completed as required, therefore reducing the risk of cross infection. However, on Conway ward the items that required daily cleaning had not been completed on the 4 and 5 June 2016.

Environment and equipment

- All the areas we visited were bright and well organised; however there was limited space in the communal area of the teenage and young adult unit and very little ventilation.
- Each ward had designated toilets and showers for male and female patients.
- Each clinical area had resuscitation equipment readily available. There were systems in place to ensure it was checked and ready for use on a daily basis. Records indicated daily checks of the equipment took place on all of the wards and units we visited. This meant there was emergency equipment available and in date when required.
- There were systems to maintain and service equipment. Records indicated that the defibrillator equipment had been checked and hoists had been serviced regularly. Electrical equipment was tested regularly and electrical safety certificates showed it had been tested within the last 12 months.
- On the wards there were needles and sharp instruments in unlocked trolleys which meant there was a risk that these were accessible to patients and the public.
- Environmental risk assessments had been completed for all the wards and services we visited.

Medicines

- Between March 2015 and March 2016 there were 142 medication errors reported in integrated care services. From the information we received it was not clear how many of these resulted in harm.
- Staff were able to describe a change following medication incidents. For example the pharmacy team now attach stickers to oral chemotherapy medication to ensure that other hospitals or care staff were aware the medication is a form of chemotherapy.
- We looked at the prescription and medicine records for 10 patients. We saw arrangements were in place for recording the administration of medicines. These records were clear and fully completed and any omissions of medication were reviewed.
- Medicines requiring cool storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were completed on the wards we visited. On questioning, staff knew how to reset the thermometer to check the fridge temperature range.
- Controlled drugs (medicines which are required to be stored and recorded separately) were stored and recorded appropriately. Access was limited to qualified staff employed by the trust. Two nurses were observed following the correct procedures for the recording and administration of controlled drugs for a patient.
- Emergency medicines were available for use and records indicated these were regularly checked
- Chemotherapy medication was managed in line with policies and procedures on the wards. It was correctly labelled, stored securely and appropriately in fridges.
- We observed medication rounds on the wards. We heard nurses ask patients their name and date of birth before administering medication. This helped staff to ensure they were giving prescribed medicines to the correct person. Staff wore red tabards to indicate that they were administering medication. This ensured they were not interrupted whilst giving out medication to patients which helped reduce the number of medication errors.
- Patients were provided with a lockable drawer or cupboard in which to store their medication. Patients were able to take their medication at the times they were used to taking it at home. This meant that patients

were given a choice and steps were taken to maintain their independence. We saw completed self-medication assessment forms but out of six we reviewed three were not signed by the patient.

- A member of the pharmacy team visited medical wards regularly. Pharmacy staff checked that the medicines patients were taking when they were admitted to the wards were correct and that records were up to date.
- Suitable cupboard and cabinets were in place to store medicines. This included a designated room on each ward to store medicines. We sample checked medicines on the wards and found them to be in date, indicating there was good stock management systems in place.
- Nursing staff undertook annual training in medicines management. The compliance rate was for nurses on the wards was 86% which was below the trust target of 95%.

Records

- We reviewed 23 care records. We saw that recent entries were easy to follow and had detailed information for patients' care and treatment and all had a completed nursing assessment and a clinical management plan.
- Patient records included a range of risk assessments and care plans that were completed on admission and were updated throughout a patient's stay.
- Patient information boards respected patient confidentiality by not being visible by patients and the public. Patient information boards provided, at a glance, an overview of the key risks, medication and discharge plans for each patient.
- The majority of patient paper records were kept in the ward office, however on Mersey ward there was a record trolley that was unlocked and left unattended. This increased the risk for patient confidentiality to be breached. Observational charts were kept by the patient bedside and we found out of the 13 sets of records we reviewed three had patient information that was not secured in the folder. This meant there was a risk that important information may be lost.
- As part of the nursing quality indicators it was noted on the wards that not all clinical notes included a past medical history. Actions had been put in place to improve the quality of the notes, for example, General Medical Council guidelines on good record keeping being available for all staff.

• The trust had recently implemented a new electronic patient record and staff reported that they had received good support and training on the new system. We observed trained IT staff supporting nurses on the wards we visited.

Safeguarding

- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse. The trust had a safeguarding lead who provided guidance during the day in the week. Staff had access to advice out of hours and at weekends from the on-call manager.
- Training statistics provided by the trust showed that 95% of staff on wards had completed level 1 safeguarding adult training. This was meeting the trust target of 95%
- The trust target for safeguarding children was 95% and compliance rates for safeguarding children level 1 was 90% and level 2 was 70%.
- Basic Safeguarding training was included in induction training for all temporary staff before commencing work on the wards.
- The number of safeguarding referrals made by the trust was relatively low with only five being made for all services in 2015. However, staff we spoke had a clear understanding of the trust safeguarding policy.
- Staff on the wards told us they received feedback from safeguarding referrals they made. They also received feedback and learning from other safeguarding referrals at team meetings and in safety huddles.

Mandatory training

- Staff received mandatory training on a rolling basis in areas such as infection control, manual handling and fire. The trust target was 95%.
- At the time of our inspection the majority of staff on the wards had completed their mandatory training that they were required to do. However, there were some areas that fell below the trust target. For example for basic life support only 74% of staff had completed the training and only 69% of staff identified to undertake intermediate life support training had completed it. Only 68% of staff identified to undertake infection control level 2 had completed their training.
- The trust had recently included additional topics that staff had to complete as part of their mandatory

training. To improve the compliance rate they were implementing protected time for staff to complete their training. Senior manager were reviewing the number of topic areas classified as mandatory.

Assessing and responding to patient risk

- A national early warning score system (NEWS) was used throughout the trust to alert staff if a patient's condition was deteriorating. This is a basic set of observations such as respiratory rate, temperature, blood pressure and pain score and is used to alert staff to any changes in a patient's condition.
- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required, staff had escalated their concerns. There was a medical emergency outreach team which was used for patients whose early warning score was above a certain level (a score of seven or above). Repeated checks of the early warning scores were documented accurately.
- Following the implementation of the NEWS in January 2016 a snapshot audit was undertaken in April 2016 to audit the accuracy of the early warning scores. This showed that sulby ward scored 100% compliance. Conway ward scored 88% and Mersey ward scored 90%. Actions had been identified to improve standards, for example, managers to raise with staff the importance of recording observations and a full audit to be undertaken in May 2016.
- Upon admission to the wards, staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways, and care plans were put in place to ensure they received the right level of care. The risk assessments included falls, use of bed rails, pressure ulcer and nutrition (malnutrition universal screening tool or MUST).
- Nursing quality indicator audits included a review of documentation to ensure risk assessments were being completed. There were 41 standards. In May 2016 conway ward was not meeting 13 of the standards; Mersey ward did not meet 20 of the standards and sulby ward 9 of the standards. Action plans were in place to improve standards, for example, the redesign of the admission checklist on the new electronic patient record.

- Observational intentional rounds were carried out by nurses every two to four hours depending on individual need to assess patient risk on an ongoing basis. We reviewed 13 intentional rounding patient records and found six of these had not been completed regularly.
- There was a trust escalation policy for the deteriorating patient which included referring patients to a higher level of care or transferring patients to an acute trust. There had been a decrease in the numbers of patients transferred from 103 in 2014 to 85 in 2015. The main medical reason for the transfers in 2015 was for cardiac review of which 53% were transferred in hours (9am-5pm Monday to Friday). This demonstrated that the recognition and treatment of acutely ill patients was well managed.
- The number of patients who had received a venous thrombo embolism (VTE) assessment on admission was 98% between January 2016 and March 2016. This was above the trust target of 95%.
- On admission 100% of patients were screened for sepsis between January 2016 and March 2016 and those who presented with severe sepsis were given intravenous antibiotics. The compliance rate for the antibiotics between January 2016 and March 2016 was 100% but the rate for February 2016 had dropped to 82%.

Nursing staffing

- Each ward had a planned nurse staffing rota and reported on a daily basis if shifts had not been covered. The service used the safer nursing acuity tool to measure staffing levels twice a year. This was last done in February 2016
- At the time of the inspection there were six whole time equivalent nursing vacancies on the wards. This was recorded on the risk register. Actions were identified to mitigate this risk, such as a recruitment programme. Managers knew where there were staffing shortfalls and where there was surplus on other wards so that staff that could be called on if needed.
- The turnover rate for nursing staff in medical services was 14%. This was just above the trust target of 12%
- Staff on Conway ward looked after patients who needed level one and level two care. They assessed the acuity of the patients on a regular basis to determine if they were level one or level two patients. This was done to ensure appropriate skill mix of staff. Level two patients require higher levels of care and more detailed observation and intervention.

- We reviewed the use of agency and bank nurses between April 2015 and March 2016 and found there were a number of areas which used temporary staff regularly although not excessively. For example, on Sulby ward the average number of shifts filled with temporary staff was 13% and on Mersey ward this was 17%. This was for a number of reasons including vacancies and sickness.
- Wards displayed nurse staffing information on a board at the ward entrance in line with guidance contained in the Department of Health document 'Hard Choices'. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirement.
- We reviewed staffing figures for January 2016 to March 2016. The majority of wards were above the national benchmark of 80% during the day and night. The average fill rate for Conway ward was 95% during the day and 98% at night and Mersey ward was 89% during the day and 93% at night.
- However, on Sulby ward the average fill rate during the day between January 2016 and March 2016 was 70%. Also, on Sulby ward the average fill rate during the day for healthcare assistants was only 80%. Senior staff said that staffing levels were safe due to the low occupancy levels. The average occupancy on Sulby ward during this time was only 45% and there had been two incidents recorded in February 2016 due to insufficient staffing levels on Sulby ward.
- The service used the trust escalation procedures if there was a reduction in the number of nursing staff of duty. This included undertaking a risk assessment and escalating the issues to the head of nursing.
- Senior nurses who were supernummary (in addition to the planned number of nurses so they could oversee the running of the ward and assist where necessary) said they often completed shifts due to shortage of staff due to short notice sickness. This meant management tasks were often left uncompleted.
- Nursing handovers were structured and information handed over to the incoming staff included allergies, mobility of patients, incidents and expected date of discharge. Each member of staff on the ward had access to a copy of the handover sheet at the beginning of each shift.

- Rotas were completed for all medical staff which included out of hours cover for all admissions and all patients across all wards. All medical trainees contributed to this rota. There was a consultant of the week rota in place. The information we reviewed showed that medical staffing was appropriate at the time of the inspection.
- Patients did not always see a doctor at the weekends, although there was sufficient cover outside normal working hours and at weekends for emergency reviews.
- There was an on call rota which ensured there was a consultant available 24 hours a day seven days a week for advice.
- The percentage of consultants working at the trust was 54% which was higher (better) than the England average of 34%. The percentage of registrars was 34% which was slightly below (worse) than the England average of 39%. The percentage of junior doctors was 4% which was lower (worse) than the England average of 22%. Middle grade levels were about the same as the England average of 6%.
- At the time of the inspection there were three whole time equivalent consultant vacancies in the integrated care directorate. The turnover rate was 9% which was below the trust target of 12%.
- Information provided by the trust showed that locum medical staff was at 0.8% on Sulby ward between April 2015 and March 2016.
- We saw a handover meeting which was attended by the consultant as well as junior doctors and nurses. There was effective verbal communication between each other and the patients.

Major incident awareness and training

- There were documented major incident plans within medical areas and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff were aware of what they would need to do in a major incident and knew how to find the trust policy and access key documents and guidance.

Medical staffing

Are medical care services effective?

Good

We rated oncology services as 'Good' for Effective because:

- Care was provided in line with national best practice guidelines and medical services participated in all of the clinical audits where they were eligible to take part. For example the national head and neck cancer audit.
- Nutrition and fluid assessments were regularly assessed and patients were well supported in meeting their nutritional and hydration needs. There was a focus on discharge planning from the moment of admission and there was good multidisciplinary working to support this.
- Most staff said they were supported effectively and the majority of staff had received their annual appraisal which was above the trust target.
- Staff had access to information they needed to support patients.
- We found that staff members' understanding and awareness of assessing peoples' capacity to make decisions about their care and treatment was good and applications for deprivation of liberty safeguarding were completed correctly. There was good recording of both verbal and written consent.

However,

- Patients said their pain was managed effectively but pain scores were not always being completed in line with national standards.
- There was evidence of providing some services seven days a week but for other services, such as therapy services, these were only in the planning stages.
- Medical staff did not attend the multidisciplinary meetings held on the ward

Evidence-based care and treatment

• The service used national and best practice guidelines to care for and treat patients. The service were monitoring compliance with National Institute for Health and Care Excellence (NICE) guidance and were taking steps to improve compliance where further actions had been identified.

- The service participated in all of the clinical audits for which it was eligible through the national quality programmes. For example the national head and neck cancer audit and the national oesophago-gastric cancer audit.
- Where the service was meeting the appropriate care score target, action plans were still completed following the clinical audit to address areas identified for improvement. For example, an action plan had been put in place to improve the results of the national lung cancer audit. This included reviewing the pathway from diagnosis to treatment to ensure it is as expeditious as possible.
- Care pathways were in place for patients. These included the prevention and management of sepsis and the prevention and management of venous thrombo embolism. The care pathways were based on NICE guidance.
- There were frequent recent local audits that had been completed on the wards. These included documentation and sepsis audits. Senior staff said they received the results of the audits and any learning was shared with them via email.
- Local policies and procedures were followed in relation to the care of patients. The service actively engaged with research networks and recruited well to national research studies. For example the study of therapy for patients with bladder cancer.

Pain relief

- The majority of patients told us they were consistently asked about their pain and supported to manage it. However, two patients told us that their pain was not being managed well and in one case this was raised with senior staff who arranged for the patients' case to be reviewed and provided with adequate pain relief.
- We saw that patient's pain levels were recorded on early warning scores documentation. We reviewed 13 records to see if pain levels were being recorded regularly and found six of these had not been recorded regularly. This was not in line with the core standards for pain management services in the uk (Faculty of pain medicine 2015).
- The service undertook audits to look at the monitoring of pain. This involved speaking with patients and

checking documentation. In March 2016 conway and mersey ward scored amber and sulby ward scored green. There were no actions identified for improvement on the information provided by the trust.

 Medication administration records indicated when patients could be given additional as necessary (PRN) medication. This meant patients could have additional pain relief when required.

Nutrition and hydration

- Patients we spoke with said they were happy with the standard and choice of food available. If patients missed a meal, as they were not on the ward at the time, staff were able to order a snack for them.
- We saw there was a comprehensive selection of meals available from a menu which was available for patients. Meals were also available for patients with different dietary, cultural and religious requirements; for example, halal meals.
- We saw drinks were available and in reach for all patients.
- The hospital used the malnutrition universal screening tool (MUST) to assess patient's nutritional needs. An audit of the completion of the tool was undertaken and in October 2015, 100% of inpatients had their MUST score calculated within 24 hours as outlined in NICE guidance. However the audit highlighted that the trust system designed to help staff identify patients who require assistance at meal times was not always being used. Actions had been put in place which included refresher training for all staff.
- The trust undertook an audit of the fluid policy in December 2015. Wards were not meeting all the standards and actions had been identified to improve standards. For example, adding fluid management on ward round templates and placing posters on wards to raise awareness.
- We looked at nutritional and fluid charts for 10 patients. They had been fully completed.
- When patients had a poor intake of food due to their condition, medical staff prescribed appropriate dietary supplements.
- Patient records showed there was regular dietician involvement when patients were identified as being at risk.
- Trust patient led assessments of food (PLACE) in 2015 showed a standard of 76%. This was lower (worse) than the England average of 88%.

Patient outcomes

- The readmission rate was worse than the England average for elective (planned) admissions and better than the England average for non-elective (unplanned) admissions.
- We looked at 10 records to see if they had been seen by a consultant within 14 hours of admission and found they had all been seen and it had been recorded on the system.
- The service monitored the compliance of patients having a documented assessment from a consultant within 14 hours of admission and had a target of 75%. In February 2016 the compliance rate was 84%.
- The service monitored acute kidney injury (AKI) indicators. This included the plan to monitor kidney function after discharge and information such as blood tests required, recorded on the discharge summary. In February the compliance rate was 44% which was worse than the previous month which was 100%. Actions had been identified to improve the outcome for patients. For example, ensuring the discharge letter produced on the electronic patient record included the AKI care bundle information.

Competent staff

- Staff told us they received an annual appraisal. The trust's figures at the end of March 2016 showed 90% of nursing and other staff on the wards had received their annual appraisal. 80% of medical staff had an appraisal. The trust did not have an official target but services were monitored if the figure was below 95%.
- The trust did have a clinical supervision policy but not all clinical staff were aware of the policy. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. Nurses told us that they did have regular meetings with their manager and they were able to speak to their manager at any time.
- Staff we spoke with confirmed they had an adequate induction. Newly appointed staff said their inductions had been planned and delivered well.
- There was a preceptorship programme in place which supported new junior nursing staff. Their competency in

undertaking care procedures were assessed by qualified staff. We saw that competency records were available on each ward, which ensured managers were aware of the skills staff had.

- There were two 'step-up' beds on Conway ward for patients who required a higher level of care and competencies had been developed for nurses to meet the needs of these patients. We saw completed competency files on conway and mersey ward.
- Sulby ward was piloting having first year nurse students. We saw records that indicated there were adequate mentors for the students to ensure they were fully supported to deliver effective care to patients.
- Staff were actively supported to undertake additional training and education to enhance their skills. For example, nurses were being supported to undertake leadership courses with the northwest leadership academy.
- Staff in bands 1 to 4 were offered opportunities to undertake appropriate vocational qualifications. There was a number of staff in medical services which had gained such qualifications.
- Wards ensured healthcare support workers undertook the care certificate. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles such as healthcare assistants.
- We saw there was a range of specialist nurses; for example a lead for dementia and nutrition. Staff told us they knew how to contact these specialists and felt supported by them. However, there was not a specialist tissue viability nurse at the trust to provide support to staff for the management of pressure ulcers.

Multidisciplinary working

- Multidisciplinary team (MDT) working was established on the wards. We saw good examples of MDT working on all of the wards we visited. This included nursing staff as well as therapy staff such as a physiotherapists and specialist nurses. However at the MDT meeting on conway ward we observed that there was no representation from medical staff. Staff said that there had been difficulties getting medical staff to attend. This meant there was a risk that important information about patients may not be fully discussed.
- Ward teams had access to the full range of allied health professionals and team members described good,

collaborative working practices. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date.

- Staff had access to psychiatric services that provided advice and support to staff.
- Daily ward meetings were held on most of the wards we visited. These were called safety huddles and they reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge. However, some staff said these meeting would benefit from daily inclusion of doctors and therapy staff.
- Patients were referred to community services if they required ongoing aftercare.

Seven-day services

- Staff and patients told us diagnostic services were available 24 hours a day, seven days a week.
- There were two consultants available on site during the day 9am to 5pm Monday to Friday. Out of hours cover was provided by a junior medical trainee from 9am to 9pm seven days a week. Support was provided by a non-resident specialist registrar and a consultant. Senior management staff said that there were plans in place to provide consultant availability on site seven days a week.
- Physiotherapy services were only available five days a week but plans were in place to provide this seven days a week. However, there was an on-call service available from a neighbouring hospital via a service level agreement.
- Pharmacy services were only available seven days a week, with an out of hours emergency on call rota to ensure patients' medication was available on discharge.
- The triage clinic was only available five days a week but plans were in place to provide this seven days a week. Recruitment of additional staff had commenced.

Access to information

• Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments, and medical and nursing records.

- There were computers available on the wards we visited, which staff accessed for patient and trust information. Policies, protocols and procedures were kept on the trust's intranet, which meant staff had access to them when required.
- On the majority of wards there were files containing minutes of meetings, ward protocols and audits, which were available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The majority of staff we spoke to knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care.
- Between January 2015 and December 2015 there had only been five DoLs applications across the trust. However, staff had knowledge and understanding of the procedures relating to the Deprivation of Liberty Safeguards (DoLs). DoLs are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. This includes people who may lack capacity. We saw examples of DoLs paperwork completed fully and accurately. Formal capacity assessments were also recorded.
- MCA and DoLs training had only recently been introduced into the training programme for staff. However every staff member had received the quality and safety handbook which informed them of trust policies in relation to MCA and DoLs.
- Staff had the appropriate skills and knowledge to obtain consent from patients. The staff we spoke with were clear on how they sought verbal informed consent and written consent before providing care or treatment. We saw written records that indicated consent had been obtained from patients prior to procedures or treatment. not attend the weekly multidisciplinary meetings on the ward.

Are medical care services caring?

Outstanding

W?

We rated oncology services as 'Outstanding' for Caring because:

- Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with people were person-centred, and people we spoke with during the inspection were very complimentary about the staff who cared for them. These relationships were highly valued by the staff and promoted by leaders.
- Patients received compassionate care and their dignity and respect were maintained. Staff were highly motivated to offer support to patients which was kind and caring and they were willing to go the extra mile. Complementary therapies and pet therapy were cailable for patients. There were examples of staff making sure acutely ill patients were involved in major life moments despite their illness and treatment.
- Staff had supported a patient who had initially been very scared about coming to the hospital. Staff from the ward came and spent time with them in reception and put them at ease.
- A patient, who was acutely unwell was supported to be present at the birth of their child and staff arranged for the family to be together at the hospital for the first few important days of family life.
- Patients and their relatives were supported with their emotional needs and there were services in place to provide support for patients and relatives. Patients could be referred to external counselling services if they required ongoing support. Care involved the family unit and families were encouraged and accommodated during the patients stay and treatment. Patients and their relatives confirmed they were kept informed about treatment plans and were given information to support decision-making.
- 100% of patients in February 2016 said they would recommend wards at the hospital in the Friends and Family test.

Compassionate care

- Services were delivered by caring and compassionate staff. We observed numerous examples of compassionate care provided to patients. There was an obvious positive rapport between patients and staff.
- Staff treated patients with dignity and respect and took time to interact with patients and those close to them. Patients told us that nursing staff were respectful to them and every effort was taken to ensure their privacy and dignity was protected when personal care was given. We observed that staff closed curtains between beds when delivering personal care.

- We observed patients receiving complementary therapies on the wards; for example massages.
- We spoke to 15 patients throughout our inspection. All the patients we spoke with were positive about their care and treatment. Comments included 'staff have been brilliant, they are amazing and fantastic', 'I wouldn't go anywhere else' and 'staff will go to the ends of the earth for you'. Patients said that staff always introduced themselves and treated everyone as individuals.
- The friends and family test results were very positive for the wards. However, the average response rate was 24% which was lower than the England average of 29%. Volunteers had been employed to encourage people to provide feedback and help increase the response rate. The friends and family test asks patients how likely they are to recommend a hospital after treatment. 100% of patients in February 2016 said they would recommend wards at the hospital.
- In the cancer patient experience survey for inpatient stay 2013/2014, the trust ranked within the top 20% of all trusts for seven of the 34 areas. These included 'having confidence and trust in all ward staff', 'always being treated with respect and dignity by staff' and 'possible side effects explained in an understandable way'. However, the trust fell within the bottom 20% of trusts for three of the areas; for example, not giving a complete explanation of what would be done.
- We saw that people had access to call bells and staff responded promptly.
- The trust performed around the same as the England average in dignity and wellbeing of the patient-led assessments of the care environment (PLACE).
- The trust performed better than similar trusts in seven of the 12 areas of the 2014 CQC inpatient survey.

Understanding and involvement of patients and those close to them

- Patients all had a named nurse and consultant. Patients were aware of this, and on the wards we visited, the relevant names were displayed on a board above the bed. Patients said they had been involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.
- Patients said they felt safe on the ward and had been orientated to the ward area on admission. Family

members said they were kept well informed about how their relative was progressing. Patients we spoke with said they had received good information about their condition and treatment.

- Welcome information was available on the wards for patients and their relatives, which informed that about visiting times, access to the hospital, meal times and what different staff uniforms meant.
- Matron leadership rounds were conducted once a week where they spent time talking with patients to find out how they were feeling about their stay at the hospital.
 Following these rounds the matron feedback to staff on the ward their findings to address any immediate concerns.
- Family members were able to stay with patients on the teenage and young people unit and wards provided pull down beds in the patients' bedroom. This enabled family members to be together during treatment.
- Children were supported to visit parents on the wards and staff arranged picnics for families to help ensure children felt at ease when visiting.

Emotional support

- Staff felt they had sufficient time to spend with patients when they needed support.
- Visiting times for the wards met the needs of the friends and relatives we spoke to. Open visiting times were available if patients needed support from their relatives.
- We were told that staff had supported a patient, who was acutely unwell, to be present at the birth of their child and arranged for the family to be together at the hospital for the first few important days of family life.
- Patients and those close to them told us that clinical staff were approachable and they were able to talk to them if they needed to. Patient anxieties and questions were openingly discussed and patients spoke positively of the emotional support they received.
- A patient said that they had initially been very scared about coming to the hospital and could not get past the front door without crying. Staff from the ward came and spent time with them in reception and put them at ease. They are now much more confident about receiving the treatment they require.
- There were quiet rooms on the ward for patients and relatives to use.

- To provide patients with emotional therapy the wards regularly received visits from Pets at Therapy services. Patients spoke very highly of the service that visited the wards and how it offered them comfort and support
- Each ward also had a hand bell available which patients rang to signify that they were at the end of treatment as a way of celebration.
- The teenage and young adult team facilitated monthly peer group to come together and do activities to provide emotional support. For example, pizza evenings or afternoon tea for patients and families.
- Chaplaincy services were available for patients and relatives if required.

Are medical care services responsive?

Good

We rated oncology services as 'Good' for Responsive because:

- Services were planned to meet the needs of the local people that were flexible, adequately resourced and provided choice.
- There was sufficient bed capacity to meet the needs of patients and systems in place for the management of patients so they had continuity of care. In addition, number of patients who experienced one or more ward moves during their admission did so only as part of their care pathway.
- Specialist nurses provided support and advice to staff and the service was meeting individual needs for patients who were living with dementia or a learning disability. There was a proactive approach to understanding the needs of different groups of people including those with complex needs.
- People were supported to raise a concern or a complaint. Complaints were investigated and lessons learnt were communicated to staff and improvements made.

However,

• The dementia strategy was not embedded in services and there were limited resources and signage to support people living with a cognitive impairment.

- Although there were specialist nurses there was not a designated tissue viability nurse to support staff in managing patients with conditions such as pressure ulcers.
- At times there were delays in patients receiving therapy from therapy staff due to the lack of staff available

Service planning and delivery to meet the needs of local people

The facilities and premises were appropriate for the services that were planned and delivered. Wards were being remodelled with the creation of five ambulatory assessment beds with a direct link to the triage clinic. Patients with acute problems would be seen on an outpatient basis and the service would be open between 8am and 8pm. The types of patients that would be seen were those with low risk fever, blood transfusion and suspected venous thrombo embolisms.

Access and flow

- Between April 2015 and December 2016 the average occupancy rate of wards was 64%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital. However, this was not the case on the wards.
- The average length of stay for elective care in oncology was longer (worse) than the England average at 2.5 days. The England average was 3.8 days. For non-elective (not planned) was 8.2 days and was longer (worse) than the England average of 6.8 days.
- In the period April 2015 to March 2016, only 15% of patients experienced multiple ward moves during their stay. This was the same as the previous year. The moves were part of the patient care pathway through services. There were no patient moves after 10pm at night.
- There was a clear bed capacity escalation procedure to ensure there was a safe flow of patients from admission through to transfer or discharge.
- The hospital held bed management meetings on a Monday to Friday to discuss staffing and bed availability. The bed status was recorded five times a day by the bed co-ordinator attending the wards.
- There was an allocated social worker for the wards, who supported discharges by ensuring referrals made to other agencies for support post discharge were in place.

Discharges were mainly managed by the wards and there were clear pathways to support effective discharges. Discharge arrangements were discussed at the daily handover meetings.

- All patients received a copy of their discharge letter, either at the time of discharge or through the post.
- Oncology services had a referral to treatment time (RTT) target of 90%. Between October 2015 and February 2016 this was either meeting the target or exceeded the target.
- The trust had a triage services that provided 24 hours nurse led telephone support to all patients receiving cancer treatment provided by the trust. Patients were assessed to ensure they received the care they required. This included advice, admission to a ward or an appointment in the triage clinic or outpatient clinic. The service used the UK oncology services (UKONS) rapid assessment and access validated toolkit to triage patients.

Meeting people's individual needs

- The trust used a falling leaf symbol of a person falling to indicate that a patient was at risk of falls. This alerted staff to look at the risk assessment and care plan to ensure that any necessary reasonable adjustments were made.
- The hospital did not use the 'forget-me-not' sticker scheme on the wards. This was a discrete flower symbol used as visual reminder to staff that patients were living with dementia or were confused. This was to ensure that patients received appropriate care, reducing the stress for the patient and increasing safety.
- None of the wards we visited had dementia friendly signage or environment, such as different coloured flooring or clear large pictures on the toilets or bathrooms.
- Wards did not use red trays to indicate if a patient needed assistance with eating. They did provide plate guards and special knives and forks for patients that required them
- There was a clinical specialist who was the clinical lead for dementia. This was a new post and they provided support for staff and a central point for queries. The trust also had access to psychiatric services that saw and assessed patients with a cognitive impairment, if required.

- On admission patients over 75 were assessed for dementia against set criteria, and support and further assessments were identified if required. In January 2016 100% of patients over 75 were assessed but in February this fell to 83%. This was below the trust target of 90%.
- The service had a strategy and action plan in place to implement the recommendations outlined in the national dementia strategy. The trust dementia strategy was relatively new and had only been ratified in February 2016. The objectives included a shorter length of stay for patients living with dementia, to reduce the number of antipsychotic medications and also improve the experience for patients. The service was also aiming to have dementia champions on the wards.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access these services.
- Patients who were deaf were placed on a ward were staff were available to communicate with them in sign language. This was in addition to external support provided.
- Leaflets where available for patients about services and the care they were receiving. Staff knew how to access copies in an accessible format for people living with dementia or learning disabilities.
- People with a learning disability were offered pre-procedure appointments to help support them with the unfamiliar surroundings and family members were supported to stay with the patient if required.
- For people who had a learning disability reasonable adjustment care plans were put in place.
- Care plans we saw were not always personalised to identify individual needs but did contain the necessary information to ensure that patients were not at risk and their care was managed safely.
- There was a teenage and young adult team which provided support to young people using services at the hospital. This included a social worker, a co-ordinator, a psychologist and a support worker.
- Patients on the teenage and young adult unit were appointed a social worker to assess their social needs including education where appropriate. For those not able to attend school due to treatment, the trust arranged for home schooling opportunities and had supported young people to complete exams on the unit.
- Due to the number of allied health professionals, such as physiotherapists and occupational therapists, they were not always able to respond to patients as quick as
Medical care

they would like to. For example, patients with spinal cord compression should be seen within 48 hours but on occasions it had been up to a week before they were seen. We asked the trust for specific data regarding number of patients not seen due to lack of therapy staff but this was not available.

Learning from complaints and concerns

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- Patients told us they knew how to make a complaint. Posters were displayed around the hospital detailing how to make a complaint, although they were only small and not prominently displayed on some of the wards. Leaflets detailing how to make a complaint were readily available in all areas.
- The trust recorded complaints centrally on the trust-wide system. The local ward managers and matrons were responsible for investigating complaints in their areas. Ward managers told us how they were working to achieve 'on the spot' resolutions of concerns where possible.
- During the inspection a family member raised some concerns with the inspector. This was raised with the trust and we observed the complaint being responded to in a timely and effective way.
- Information provided by the trust showed there had been five complaints raised across the wards between February 2015 and January 2016. All complaints had been acknowledged and responded to within the agreed timeframe.
- An example of learning from a complaint was a change to the telephone number and processes of the triage service to ensure patients were able to receive advice without having to go through the main switchboard.
- Complaints were discussed at governance meetings which also outlined key lessons learnt to be shared with staff. Staff told us managers discussed information about complaints during staff meetings to facilitate learning.

Are medical care services well-led?

We rated oncology services as 'Good' for Well-led because:

• Oncology services had effective communication within teams. The visibility of senior management was good and there were information boards to highlight the ward's performance displayed on each ward area.

Good

- There was a specific service delivery plan which included the wards and full engagement in the trust strategy and plans.
- There was a clear governance structure and risk registers were in place and had actions identified. Staff felt supported and able to speak up if they had concerns. Oncology services captured views of people who used the services with learning highlighted to make changes to the care provided. People would recommend the hospital to friends or a relative. There was good staff engagement with staff being involved in making improvements for services.
- All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

However,

- On the information from the hospital at the time of the inspection the actions on the risk register did not have a clear time frame identified and the risk register was not discussed at the main governance meeting. This meant we were not assured that risks were being actioned in in timely way.
- It was not clear if any learning from incidents was discussed at the governance meeting to ensure wider learning was shared across the wards.

Vision and strategy for this service

• The trust's vision was summarised 'to provide the best cancer care to the people we serve'. The values were putting people first, achieving excellence, passionate about what they do, always improving care and looking to the future. Staff were aware of the vision and values and these were displayed on the notice boards.

Medical care

- The Trust's strategic objectives were based on this vision and these objectives were cascaded down to service and individual objectives for staff.
- Integrated care services had a service delivery plan. The objectives included delivery of safe and effective inpatient services and the appropriate bed resources for all planned and unplanned admission. Key milestones and risks were clearly identified.
- Services were part of the living with and beyond cancer in Merseyside and Cheshire project. This project was based on the new cancer taskforce report and five year forward review. The project had measurable outcomes and work streams. For example, assessment and care planning, consequences of cancer and its treatment and patient experience and engagement.
- NHS staff survey results for 2015 showed that 80% of staff at the trust said they had clear planned goals and objectives. The number of responses was 381.

Governance, risk management and quality measurement

- The risk register highlighted risks across medical services and actions were in place to address concerns. For example, risk of infection.
- Risks were reviewed regularly; however, we were not assured that risks were being managed in a timely way as actions to mitigate the risk did not have a clear time frame identified.
- Risks were reviewed regularly; however, we were not assured that risks were being managed in a timely way as actions to mitigate the risk did not have a clear time frame identified on the information provided by the trust at the time of the inspection. Senior staff knew there was a risk register and ward managers were able to tell us what the key risks were for their area of responsibility.
- There was a governance reporting structure in integrated care services and the main governance meeting was held on a monthly basis. We reviewed the minutes of the meeting held between January 2016 and April 2016. Although the number of incidents were reported at the meeting, it was not clear if learning and trends from incidents had been discussed. The risk register had not been discussed at the meetings held

between January 2016 and April 2016. Actions from the meeting were identified but the date the action was to have been completed (in order to help track progress) was not always clear.

- Staff were not able to tell us how their ward performance was monitored, though they were aware that data was collected and discussed at governance meetings.
- The clinical director and general manager provided a report on the performance of integrated care services on a quarterly basis. This was a thorough report and outlined the key performance data and actions to improve standards were required.
- Staff said that multidisciplinary team meetings were held regularly on each medical ward. There was evidence on the majority of wards that regular team meetings took place and these were minuted and cascaded to staff via email. There was also a copy of the minutes in a file on the ward for staff to read. However, on sulby ward we found that there were occasions when it was unclear if ward meetings had taken place during a period of absence of the ward manager.

Leadership of service

- Staff reported there was clear visibility of members of the trust board throughout the service. Staff could explain the leadership structure within the trust and the executive team were accessible to staff.
- All nursing staff spoke highly of the ward managers as leaders and told us they received good support. We observed good working relationships within all teams.
- Doctors told us that senior medical staff were accessible and responsive and they received good leadership and support.

Culture within the service

- The majority of staff said they felt supported and able to speak up if they had concerns. For example staff had raised concerns regarding a blood transfusion and this prompted a review of the patient's management plan.
- Staff on the wards had completed a stress survey and were being encouraged to attend focus groups to improve work life balance for staff. The focus groups included management of change and leadership and management.

Medical care

- Staff from the wards took park in Schwartz meetings which provided an opportunity for staff to reflect on the emotional aspect of their work. This had a positive impact on patient outcomes and organisational culture.
- Integrated care directorate had developed an action plan following the staff survey 2015. For example, to review staffing levels to ensure they were adequate and ensure earlier engagement of staff regarding any changes so they felt fully supported. There was also going to be an analysis into the response rate as the majority of responses were from Mersey ward.

Public engagement

- The trust published patient stories as part of their open and honest care programme which was available on their website. They also heard a patient story at each trust board meeting and any learning was taken forward to improve services. This included feedback from patients on the wards.
- Wards undertook a local patient survey regularly about their staff at the hospital. Between November 2015 and January 2016, 98% of patients said they felt well looked after on the wards and were treated with courtesy and respect.
- In April 2016 services undertook a survey of the triage service and looked at all standards, such as the time it took to answer the call and if patients needed a medical review, where they would like to be seen. An action plan had been put in place to improve service. For example, the development of a business case for investment in additional trained staff and healthcare assistants.

Staff engagement

• There was an employee of the month scheme which recognised staff who had gone the extra mile to provide patient care. There were several staff from the wards who had received this award.

- Staff participated in the 2015 staff survey. This included how staff felt about services and their personal development. Seventy percent of staff at the trust felt the training and development they had undertaken had helped them to deliver a better patient experience and 78% felt it had helped them to do the job more effectively. Sixty-eight percent felt they were valued by their manager. These scores were all about the same as the national averages.
- Staff received a weekly e-bulletin informing them of different projects they may want to be involved in. For example, staff on the wards had been involved in the review of admission and blood transfusion processes.
- Staff were actively encouraged to take part in projects outside the organisation and ward staff had been involved in the development of the Royal College of Nursing (RCN) Teenage Cancer Trust Staff Competency Framework for Nursing.

Innovation, improvement and sustainability

- Wards were involved in the older person's project which was looking at the additional needs of individual patients aged 65 and over. The aim was to develop an electronic patient screening tool to identify risk and those at need of further assessment.
- Wards were also involved in the patient and family centred care project looking at patient outcomes, satisfaction, safety and staff satisfaction. This project was brought forward following a complaint and aimed to be completed by September 2016. Staff had also visited a neighbouring trust to look at how they had implemented patient centred careder learning was shared across the wards.

Safe	Good	
Effective	Good	
Caring	Outstanding	公
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

Clatterbridge Cancer Centre provides specialist care and treatment to patients across the North West, North Wales and the Isle of Man. The hospital had 3,760 admissions between April 2015 and March 2016 and had a low number of deaths during the same period (74).

The hospital had three inpatient wards and a total of 74 beds, with a mixture of open plan areas and doored side rooms. There was also a four bedded young peoples' unit that was found on Mersey Ward. There was not a designated ward or area for patients who were at the end of life.

End of life services were provided and led by a team of specialist palliative care nurses and a consultant in palliative care medicine, who provided direct care and treatment to patients and supported staff throughout the hospital.

We visited the service on the 7, 8 and 9 June 2016 as part of the announced visit, and we completed the unannounced element of the inspection on the 21 June 2016.

During our visit we spoke to patients and relatives as well as a number of staff including managers, consultants, doctors, nurses, health care assistants, porters, chaplains and social workers. We reviewed information that we received from the trust before and after the inspection, observed care and treatment being provided and reviewed a sample of patient documentation.

Summary of findings

We rated end of life care services as 'good ' overall because;

- End of life services were led by a dedicated specialist palliative care consultant and a team of specialist nurses who were dedicated to providing the best possible care and treatment.
- The SPC team had developed a clear vision and strategy which was supported by an end of life care work programme which were aimed at improving the current services provided further.
- The SPC consultant was involved in a number of different projects to improve end of life services not only at the trust, but also nationally.
- We found that the numbers of nursing staff on inpatient wards were adequate to provide care and treatment to patients at the end of life.
- We found that both the SPC team and general staff on the inpatient wards were keen to tell us how proud they were of the service that they provided. All staff were committed to high quality, compassionate care.
- End of life services had been developed and were delivered in line with current best practice guidance. The service had responded to the Liverpool care

pathway being withdrawn by implementing an individual communication record which had been designed to meet individual needs of patients at the end of life.

- The service made regular contributions to the National Care of the Dying Audit and the most up to date records from January 2016 showed that the service performed better than other services nationally in all ten clinical indicators.
- We saw some positive examples of multi-disciplinary team working. End of life services were everybody's responsibility and the SPC team provided a good level of support to nursing and medical staff on the inpatient wards.

However,

- The SPC team were not currently able to provide a seven day service. There were plans in place to introduce this in September 2016.
- End of life care training had been included as part of the mandatory training programme for all staff.
 However, there was currently a low level of compliance with this.
- The service did not currently use advanced care planning and were not part of the gold standard framework accreditation scheme.
- There was limited evidence of incidents and complaints being discussed in governance meetings which meant that it was unclear how lessons were being learnt and improvements were being made.
- The trust had a service level agreement in place with another hospital for the provision of on-site mortuary services. However, we found that there was no assurance that this was being monitored appropriately through key performance indicators.

Are end of life care services safe?

We rated end of life care services as being 'good' for safe because;

Good

- We found that staffing levels on inpatient wards were sufficient to provide care and treatment to patients at the end of life.
- There had not been any reported never events or serious incidents associated with the palliative care team or end of life care services. Incidents that had been reported had been investigated and actions had been implemented to reduce the risk of them happening again.
- We found that anticipatory medicines were stored appropriately and were available to be used when required. Staff had regard to the use of syringe drivers and there were sufficient numbers of staff trained to use them.
- We found that records were completed to a good standard and that they were stored appropriately. The trust had recently started to use an electronic system to store some patient records and staff were competent in its use.
- There was a safeguarding policy which staff were able to locate. Staff told us about types of safeguarding concerns that they would report and were able to describe the process to do this.

However,

- End of life care training had been introduced as part of the mandatory training programme. However, there were currently low numbers of staff who had completed this.
- The trust had a service level agreement with another trust to manage the on-site mortuary facilities. However, at the time of the announced inspection, there were no clear contingency plans in place that would ensure continuity of services in the event of a major incident.

Incidents

- Incidents were recorded and documented using a paper based incident reporting system. Staff were able to identify the types of incidents that should be recorded and could clearly demonstrate how this was completed.
- There was a trust-wide incident reporting policy that was available on the intranet. Staff had an understanding of this and knew how to locate it.
- Staff gave us examples of when they had completed an incident report. However, out of 20 members of staff that we spoke to, three told us that they had not always received feedback and were concerned that paper report forms were sometimes left out on desks for everyone to see.
- Between April 2015 and June 2016 there had been no reported serious incidents or NEVER events associated with the palliative care team. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented.
- The management team told us that incidents were discussed in monthly governance meetings. However, we saw limited evidence of these having been documented in minutes of meetings. The management team acknowledged that this needed to be recorded and that the process that was used at present was not robust.
- We reviewed incident reports that were attributable to the palliative care team and end of life care between March 2015 and February 2016. During this period only 12 incidents were associated with these services and included things such as medication errors, staff shortages and when documentation had been completed incorrectly. We found that these had been investigated appropriately and actions had been taken when needed.
- Monthly hospital morbidity and mortality meetings were held so that lessons could be learnt and improvements could be made to care and treatment that was provided. However, on reviewing minutes of these meetings there was no representation at this from the end of life care team.
- Staff had an understanding of the duty of candour and when this should be applied. 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.

Medicines

- There were trust-wide clinical guidelines for prescribing anticipatory medication. Medical staff were able to locate these and were supported by the palliative care consultant and nurses when needed. Out of hours advice was provided by a local hospice via a telephone helpline and a doctor or nurse who specialised in palliative care was available when needed.
- The service had performed much better than the national average in the National Care of the Dying audit (2016) for the prescription of anticipatory medicines used to control specific symptoms at the end of life. The results of this were 100% compliance in the management of agitation or delirium, 94% in pain control, 93% in controlling difficulty in breathing, 86% in managing nausea and vomiting and 93% in the management of noisy breathing.
- We checked a sample of patient's prescription charts and found that anticipatory medicines had been prescribed appropriately and were for regular administration on all occasions. We also found that any other non-essential medications had been discontinued which was in line with national guidance.
- The service used syringe drivers to administer certain medications including pain relief. We found that there were an appropriate number of T34 syringe drivers available for all trained staff to use across three inpatient wards and that these were stored appropriately. There were also seven locked boxes available. Locked boxes were used to secure the syringe drivers so that they were not tampered with when being used to administer medication.
- If syringe drivers were being used when a patient was transferred or discharged then this was done without a locked box. However, staff always travelled with the patient to ensure safe transfer of the syringe drivers.
- The use of syringe drivers was supported by regular training which included a face to face session for newly qualified staff and updates were completed through e-learning every three years. Training records indicated

that 77 members of staff had been identified to complete this and 96% of these were up to date. We saw two examples of staff correctly calculating and administering controlled drugs to patients in line with the controlled drugs regulations 2013.

- Chemotherapy is provided in house from the MHRA licensed production unit & PharmaC (Clatterbridge Pharmacy Ltd) which provides inpatient and outpatient dispensing service along with a range of over the counter medicines and a smoking cessation service. PharmaC also supports the chemotherapy at home service. Ward top ups were provided by an external organisation through a service level agreement. Staff told us that they responded quickly if medications were required and were also available out of hours. In the event of a rapid discharge, medications were delivered within one hour.
- Palliative care nurses had not received training in non-medical prescribing but had expressed the desire to do so in the future.

Records

- The hospital used a combination of both paper and electronic records.
- An electronic system had been introduced two weeks before the inspection and training had been provided to staff for this. We found that staff were still adapting to the system but were competent in its use.
- Electronic records included risk assessments, prescription cards and medical notes while documentation such as the end of life communication record and do not attempt cardiopulmonary resuscitation (DNACPR) forms were still paper based.
- Some paper records, for example, physiological charts were kept at the end of a patient's bed or outside individual cubicles while documentation such as DNACPR forms were stored securely in a locked staff area. We found that records were tidy and well kept.
- We checked a sample of patient records and found them to be dated, signed, legible and clear to follow.
 Patients had received a daily review and conversations with relatives had been documented appropriately.

- We reviewed a sample of AMBER care bundle records and found that they had been completed appropriately on all occasions. This AMBER care bundle was used to consider things such as spiritual requirements, preferred place of care and relationships with key people.
- The trust had a (DNACPR) policy which was available to staff on the intranet and staff were able to locate this. Medical staff were able to describe the procedures for completing DNACPR forms. We reviewed a sample of DNACPR forms and found them to be completed correctly on all occasions. Documentation included conversations about their implementation with both the patient and relatives. Relatives confirmed that medical staff had discussed the DNACPR forms with them before they were implemented.
- When a patient had passed away, medical staff were responsible for completing relevant documentation and were able to describe this process. However, between March 2015 and February 2016, one incident was reported when a cremation documentation was not completed correctly which meant that the cremation of the patient had been delayed.

Safeguarding

- There was a trust-wide policy and procedure for safeguarding vulnerable adults and children. This was accessible to staff on the trust intranet and staff were able to locate it.
- There was a safeguarding lead working in the hospital and was available for referrals and advice during the day between Monday and Friday. Staff were able to seek advice from the on-call manager outside of these hours if needed.
- Staff could give us examples of safeguarding issues and were able to describe the procedure if they had a concern that needed to be raised. Safeguarding concerns were considered by the palliative care team when facilitating a patient discharge and was included as part of the fast track and rapid discharge plans.
- Staff received training in safeguarding adults and children. The trust provided level 1 and level 2 training as part of the mandatory training programme. Records

indicated that palliative care team members were up to date with level 1 training for adults and children. However, no members of the team had completed level 2 training.

- In addition, general nursing and medical staff on inpatient wards received the same training. Records showed that 95% of staff on all three wards had received level 1 training for adults and children, 90% for level 2 adults and 70% for level 2 children.
- A flagging system which identified patients who had previous or current safeguarding concerns was not used by the trust. However, staff shared safeguarding information in daily handover meetings so that all relevant information was transferred.

Mandatory training

- Mandatory training was delivered in two ways, either by e-learning which was available to all staff on the intranet or through face to face learning.
- Training for the palliative care team was facilitated by the trust learning and development team. Records indicated that compliance with statutory training was 87.1% which was lower than the trust target of 95%. This included information governance, fire safety, health and safety, equality and diversity and infection control.
- All members of the team had completed modules such as immediate life support for adults and manual handling.
- An end of life care module had been recently introduced to the mandatory training programme. This was available for all nursing and medical staff throughout the hospital and was facilitated by the SPC team. The end of life training course involved topics such as symptom control, pain management, nutrition, hydration and key priorities. Compliance with end of life training was currently low, with only 20% of nurses and 0% of doctors having completed it.

Assessing and responding to patient risk

- There was a policy for recognising and managing the deteriorating patient which was available on the intranet.
- Staff used the national early warning score (NEWS) tool to assess a patient's clinical condition. The NEWS system used clinical observations within set parameters

to determine how unwell a patient may be. When a patient's clinical observations fell outside certain parameters they produced a higher score, which meant they required more urgent clinical care or more frequent observations than others.

- There was clear guidance for staff to follow when referring patients to the medical emergency team (MET). This was done if a patients NEWS was above seven or staff had concerns that a patient had deteriorated. The MET consisted of a critical care nurse, an acute nurse practitioner and a doctor. A decision was then made if staff were able to manage the patient.
- There were two critical care nurses to manage patients on a staff to patient ratio of 1:2, providing treatment such as high flow oxygen therapy, electrocardiogram (ECG) monitoring or increased fluid therapy. The hospital did not have a high dependency or an intensive care unit so if staff were unable to stabilise a patient they were transferred to a local accident and emergency department by ambulance.
- Patients who had a do not resuscitate order in place were identified using clear signage in staff areas. This information was also included at staff handovers reducing the risk of resuscitation being carried out in error.
- All patients had risk assessments completed which included things such as falls and venous thromboembolism (VTE). We checked a sample of records and found that these had been completed in all cases.
- An individual communication record was used when a patient was recognised as being at the end of life. This document replaced all other medical notes and provided a number of key points of care for staff to consider which included things such as repositioning, mouth care and assessment of pain. In the records that we checked this had been completed appropriately in all cases.
- The palliative care team aimed to respond to all referrals within 24 hours of them being made except in the case of exceptional circumstances. Records indicated that between April and December 2015, this had been achieved in 92.6% of cases.

Nursing staffing

- The specialist palliative care (SPC) service currently employed three specialist nurses who were available from Monday to Friday between 8am and 5pm and 9am to 5pm on a Saturday.
- There was a vacancy for an additional SPC nurse at the time of inspection. Recruitment to this vacancy had taken place and the new member of staff was due to start in the near future. Following this the plan was for the team to provide a seven day service.
- An additional member of nursing staff had been recruited to work two days a week to help facilitate the AMBER care bundle and to support the introduction of advanced care planning. This was on an initial six month secondment.
- The SPC team also had a team co-ordinator and a team clerk who assisted in service delivery.
- A member of nursing staff from the SPC team attended the daily medical handover. This gave them the opportunity to address any patient concerns from overnight and to pick up any new referrals.
- The SPC team told us that it was the responsibility of all nursing staff to look after end of life patients. We reviewed nursing rotas for the three inpatient wards between January and March 2016 and found that staffing numbers were generally good. For example, on Conway ward the required number of nursing staff was met on 95% of occasions during the day and on 98% at night. Similarly on Mersey Ward staffing was achieved on 89% of occasions during the day and 93% during the night.
- Staffing was included on the palliative care risk register and was last reviewed in April 2016. Insufficient numbers of trained and untrained staff had been identified across inpatient wards which meant regular use of bank and agency staff. The trust had recently encouraged bank staff who were familiar with trust policies and procedures to fill any shortfalls.
- Nursing and medical staff on the inpatient wards told us they felt that they were able to spend a sufficient amount of time with patients at the end of life. However, between March 2015 and February 2016 one incident had been reported when the correct level of care and treatment was not provided due to the ward being busy and there being a shortage of nursing staff available.

Medical staffing

- There was one whole time equivalent consultant who specialised in palliative care medicine and was available from Monday to Friday during the day and on-call at weekends. The consultant told us that there was a need for a second consultant in palliative care medicine due to the increasing workload. However, there were no plans to facilitate this.
- When the palliative care consultant was not available during the week an on-call consultant who also specialised in end of life care was available to provide telephone support. Out of hours there was a telephone advice line that was run by medical staff and nurses who specialised in palliative care.
- Patients were referred on a daily basis and were reviewed by the palliative care consultant in order of clinical need. We were told that all medical staff were responsible for providing care and treatment to palliative care patients.
- A member of the palliative care team attended the daily medical handover and passed any relevant information to the consultant to be reviewed.

Major incident awareness and training

- The trust had a major incident and business contingency plan that was available on the intranet. This listed key risks that could affect the provision of care and treatment.
- Staff received statutory training in fire and health and safety. During this training there was also guidance and instructions to follow in the event of a major incident.
- The mortuary was run and maintained through a service level agreement with another trust. Within this agreement there were no formal arrangements that described how the mortuary would be managed if at full capacity or in the event of a major incident. The management team told us that this would be included as part of an ongoing review which we confirmed to be the case on our unannounced visit. Following the inspection, the management team provided evidence that the documentation for this had been available.

Are end of life care services effective?



We rated end of life care services as 'good' for effective because;

- Services provided were based on up to date evidence based practice. Consideration had been given to a number of NICE guidelines.
- The SPC team had responded to the Liverpool care pathway being withdrawn and had implemented an individual patient communication record that had been designed to meet the needs of patients at the end of life.
- The service measured the effectiveness of the care and treatment that they provided on a regular basis. Data contributions were made to the National Care of the Dying audit and the latest results showed that the service had performed better than others nationally in the ten key clinical performance indicators.
- We saw positive examples of multi-disciplinary team working when both providing care and treatment and recognising patients who were at the end of life. Multi-disciplinary team working was promoted by several services being located in the same area of the hospital.
- We found that appropriate pain relief was available for staff to use and on checking a sample of records had been administered in accordance with policies and procedures.
- Referrals that had been made to the SPC team were followed up within 24 hours on most occasions.

However,

- The SPC team were currently unable to provide a seven day service. However, plans to introduce this were in place once the number of established team members had been reached.
- End of life training had been introduced as an element of mandatory training for all staff at the beginning of 2016. However, we found that the level of compliance with this was low.
- The service did not currently use advanced care planning and were not part of the gold standards framework.

Evidence-based care and treatment

- Palliative care services were provided in line with up to date, evidence based practice. The service had considered best practice guidelines that had been developed by the National Institute for Health and Care Excellence (NICE).
- The service held education meetings in which best practice guidelines were discussed so that changes could be made to the service if required. We saw evidence of evidence based journal articles being made available to staff through the use of notice boards and newsletters.
- The SPC team had responded to the Department of Health's national end of life strategy recommendations in that the AMBER care bundle had been introduced in 2015. The AMBER care bundle is an approach used when the medical team are uncertain if a patient will recover despite treatment being provided. It supports patients and relatives to continue with treatment, but also facilitates discussion about their wishes for the future if the treatment is unsuccessful.
- AMBER care bundle training had been delivered to staff and it was being used on all of the inpatient wards within the hospital. Following its implementation, the SPC team had completed an initial baseline audit that measured how effective it had been so far which showed some positive results as well as areas for improvement. For example, all patients who were supported by the AMBER care bundle had DNACPR documentation in place. However, out of 50 patients, there were seven occasions when the opportunity for the AMBER care bundle to be implemented had been missed.
- The SPC team had recently been extended and a member of staff had been recruited to spend two days a week consolidating the use of the AMBER care bundle.
- The service did not currently use advanced care planning, although there had been recognition that many aspects of this were already included in care that was being provided. There were plans for this to be formally introduced and it was to be the AMBER care bundle facilitator's responsibility to complete this.
- The SPC team had responded to the review of the Liverpool care pathway in 2013 by implementing an

individual patient communication record which provided clear guidance for staff when managing a patient at the end of life. This document could be adapted to each individual patient while meeting the priorities of care of the dying person which had been set out by the leadership alliance for the care of dying people. The key priorities are recognising and communicating that a patient is dying, patients and those close to them are involved in all discussions about their care, the needs of family members and others are considered when providing care and an individual plan is implemented which considers food and drink, symptom control, as well as psychological and spiritual support.

- The effectiveness of the patient communication record had not yet been measured as it was still being piloted. The SPC team told us that this was in progress and data would be used to compile a baseline audit once there had been a sufficient number of patients who had used it.
- The service had introduced a 24 hour advice line as the SPC team were only available 6 days a week during the daytime. The SPC team had measured the effectiveness of this service so that they were assured that staff had access to the right support at times when they were not available.
- Records indicated that the SPC team had received 535 referrals between April 2015 and March 2016 and that patients had been reviewed within 24 hours on 92.6% of occasions during this period.

Pain relief

- The specialist palliative care (SPC) team provided support and advice about the administration of pain relief for patients at the end of life. In addition, the SPC team provided pain management support to all other patients in the hospital. There was a referral process for staff to follow that included patients with uncontrollable pain.
- Out of hours, advice on pain management was accessed through an on-call consultant or through the 24 hour advice line provided by a local hospice.

- Pain was assessed on a risk based scale of low, medium and high. When a patient was at the end of life an individualised communication record was implemented and pain assessment was included as part of this.
- Appropriate medication for pain management was available for staff to use and anticipatory prescribing was managed well. We reviewed a sample of records and found that patients who had received pain relief had been monitored regularly by staff, assessing the efficacy of the treatment given and we found that this had been documented appropriately. Patients and relatives that we spoke to confirmed that pain had been managed well.
- There was a trust-wide policy for the storage and use of opioids which was available on the intranet. Staff were knowledgeable about policies and procedures regarding this.
- The trust-wide audit team had completed an audit in March 2016 of the use of opioids against the standards set by the National Institute for Health and Care Excellence (NICE CG140). Results from this audit were mixed, for example patients starting treatment were offered regular oral-sustained release or immediate release morphine and patients were offered rescue doses on 89% of occasions. However, specialist advice was sought for patients who had hepatic impairment on only 40% of occasions and anti-emetics were prescribed appropriately on only 70% of occasions. Recommendations had been made for improvement including education sessions, an introductory lecture for medical staff and for a re-audit to be undertaken measuring improvement.
- In addition results from the National Care of the Dying Audit (2016) showed that anticipatory pain relief had been used appropriately in 94% of cases.

Nutrition and hydration

- All care plans included an assessment for nutrition and hydration. Inpatient wards used a malnutrition universal screening tool (MUST) to assess the individual needs of a patient. We checked a sample of records which indicated this had been completed on all occasions.
- There was a selection of food and drinks available for patients. During the inspection we saw meals being provided appropriately.

- In response to the Liverpool Care Pathway (LCP) being removed, a communication record had been implemented to support staff when treating a patient at the end of life. Part of this record considered the need for clinically assisted hydration which was used when patients were no longer able to eat and drink normally.
- An audit had been completed by the SPC team in November 2015 reviewing the use of clinically assisted hydration for patients in the last days or hours of life. The results from this had been shared with the Cheshire and Mersey Palliative Care Network. Results from this were mixed but did show that in some areas the service was performing better than comparable services within the network. For example, 60% of patients had a discussion about clinically assisted hydration prior to being recognised as dying which was better than the network result of 11% and the benefits and burdens were discussed with those close to the patient in 75% of cases. This was in comparison to a network result of 45%.
- An action plan had been developed to make improvements and included strategies such as increased education for staff and to ensure that all decisions made are discussed as a multi-disciplinary team.
- Further advice and support was provided by a dietetic service and out of hours advice was also requested through a 24 hour help line if needed.

Patient outcomes

- The service collected data on a regular basis to assess the efficacy of the treatment that they provided, identifying areas that needed further improvement. Members of the SPC team were actively involved in this process and were able to identify areas of both positive and negative performance.
- The service had made regular data contributions to the National Care of the Dying Audit for Hospitals (NCDAH), with the latest being in January 2016. The NCDAH looks at data provided in a one month period and compares it to similar services nationally. However, we found that due to the specialist nature of this service the sample number used was considerably lower than other services. The audit team told us that they had to use three months data to have a large enough sample to take part in the audit.

- Results from the last audit were positive and the service performed better than others nationally in all ten clinical performance indicators. For example, the service recognised on 95% of occasions that a patient would die in the next few hours or days, in comparison to a national average of 83%. a conversation was had with a nominated person on 95% of occasions, in comparison to a national average of 79% and an holistic assessment of patient's needs had been completed on 100% of occasions, in comparison to a national average of 62%.
- The service had also achieved four out of seven key service performance indicators in the NCDAH 2016. The SPC team had implemented an action plan to facilitate and monitor further improvement as a result of the outcomes from the NCDAH 2016.
- The service was not currently taking part in the gold standards framework (GSF). The GSF is an independent accreditation for end of life care.

Competent staff

- All SPC team members were subject to an annual appraisal which allowed them to discuss positive and negative aspects of their performance. All staff in the SPC team had received an appraisal in the last 12 months.
- There was a trust-wide revalidation team who were responsible for ensuring that staff had re-registered with their professional bodies.
- SPC nurses were subject to ongoing training in palliative care and were well qualified to undertake their roles. The SPC nurses received constant supervision from the palliative care consultant on a day to day basis.
- There was an induction period available for staff joining the SPC team which consisted of an eight week supernumerary period. This was where staff had the opportunity to become familiar with policies and procedures while working with an experienced member of staff and not having direct responsibility for patients.
- SPC nurses were supported and encouraged to attend training courses and conferences to enhance their skills and knowledge. The SPC team held an education meeting in which they decided what training to attend and what needed improvement.

- The SPC team were involved in delivering training for end of life care which was available to staff throughout the hospital. In order to support SPC nurses in doing this they had been encouraged to attend an educator development programme that was facilitated by the Cheshire and Mersey Palliative Care Network. This included a number of classroom based days over a 12 month period.
- Regular courses were facilitated for all nursing and medical staff which included topics such as recognising dying, management of pain and agitation, management of nausea and vomiting, management of hydration and care after death. Posters were displayed on inpatient wards and staff told us that the training run by the SPC nurses was informative.
- End of life care had recently been included as part of the mandatory training programme and was currently being piloted by the service. The aim of this was to ensure that all staff were safe, effective, competent and confident when delivering end of life care.
- The SPC team were also piloting a simulation training programme that was accessible to all staff. The aim of this was to develop communication skills that were used with patients and relatives in the last days and hours of life.
- The service had worked closely with the Merseyside palliative medicine specialist training programme and medical students undertook specialist placements within the service. Records indicated that a survey had been completed asking students how effective they felt that their training had been. The overall results had been positive, with the majority of participants stating that their confidence and skills had increased following the programme. An action plan for further improvements to training had also been developed.

Multidisciplinary working

 The SPC team were involved in a number of multidisciplinary team meetings, working collaboratively with staff throughout the hospital. The SPC team told us that providing care and treatment for patients at the end of life was everybody's responsibility. Nursing and medical staff throughout the hospital spoke highly of the SPC team and found them to be accessible and supportive.

- An SPC nurse attended the daily medical handover and the weekly multidisciplinary team meeting so that patients who required an assessment or review by the team were identified. We found these meetings to be well attended, well organised and effective.
- A multidisciplinary team approach was used to identify patients who were at the end of life. The SPC team worked alongside the nurses and doctors on the inpatient wards when deciding if treatment should be withdrawn.
- The SPC team worked closely with a specialist social worker who was employed by the trust and was responsible for supporting staff when discharging patients. There were clear pathways to local community teams and hospices for staff to follow which promoted continuity of care. This resource was available on all inpatient wards for staff to use.
- The SPC team were located on the same corridor as a variety of other staff including physiotherapists, dietitians, occupational therapists, medical psychologists and the young people's team. This team was known as the CReST team and held a weekly meeting which the SPC team attended. This meeting was used to discuss individual patients, the overall effectiveness of the service and changes in clinical practice or initiatives that had been introduced.
- Staff felt that CReST was a vital part of how the teams worked together in that many services worked in close proximity of each other. We saw examples of staff seeking advice from each other on a number of occasions and supporting each other in managing difficult situations.
- The end of life service worked alongside staff from other organisations that provided care and support for patients who had cancer. This service included providing financial support to patients and relatives if needed.
- The service did not currently use an electronic palliative care co-ordination system which could be accessed by all palliative care services including those in the community and supported effective information sharing. There were no plans currently to implement this.

• The SPC team had recognised the need for input into daily ward rounds but were not currently able to facilitate this. However, there were plans in place to introduce this once the SPC team was at full establishment.

Seven-day services

- The SPC nursing team were currently available in the daytime between Monday and Saturday. There were plans to extend to a seven day service in September 2016.
- The palliative care consultant was available during the daytime between Monday and Friday. However, staff told us that she was contactable outside of these times if needed and would attend if a patient needed reviewing.
- If the consultant was not available due to things such as annual leave, a palliative care consultant from a nearby hospice was available for telephone advice.
- An advice line was available for staff to use out of hours and on a Sunday. This service was provided by a member of medical or nursing staff at a local hospice who were experienced in palliative care. They were able to give remote advice about things such as symptom management and the use of anticipatory medication.
- Diagnostic services were available 24 hours a day, 7 days a week. Pharmacy services were available within the hospital during the day from Monday to Saturday. However, outside of these hours medication had to be sent from another trust.

Access to information

- Results from patient diagnostics including blood tests and radiography were transferred electronically and were accessible to all staff in the hospital.
- The SPC team had regular communication with community nursing teams so if a patient needed admission, they made sure any relevant documentation such as DNACPR forms and advanced care plans were brought with the patient.
- If a patient was moved within the hospital, paper records were transferred with the patient and electronic information such as risk assessments were available to all staff.

- End of life services did not currently use the palliative care co-ordination system .This system allows the transfer of information between a range of services including general practitioners (GP's), hospices and community services.
- When a patient was discharged, a summary sheet was completed and a letter was sent to the patient's GP informing them if there had been any involvement from the SPC team. Paper records were also scanned on to the electronic system and were accessible to staff if needed.
- Continuity of care at the point of discharge was facilitated through the use of checklists that had been developed and were specific to individual locations such as hospices and nursing homes. Fast track and rapid discharge plans also made reference to the information that was required before a discharge was completed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy for mental capacity and deprivation of liberty safeguards which was available on the intranet.
- Training for mental capacity and deprivation of liberty had only recently been introduced to the mandatory training programme. However, all staff had been given a pocket book which informed them of key information to consider when making decisions.
- Staff knew about the key principles of mental capacity, deprivation of liberty and told us about how they gained consent prior to treatment.
- There was a safeguarding lead and a social worker who were both available during the day from Monday to Friday and supported staff in making any decisions around mental capacity assessments and deprivation of liberty. Each ward also had a resource folder with information about mental capacity and deprivation of liberty and was available to all members of staff.
- The SPC team had undertaken a DNACPR completion audit between July 2015 and May 2016. Records indicated that mental capacity decisions had only been recorded for cases where a patient had been deemed not to have mental capacity. This should have been

recorded irrespective of if a patient had mental capacity or not. We reviewed a sample of DNACPR forms and found that mental capacity assessments had been completed appropriately on all occasions.



We rated end of life care services as being 'outstanding' for caring because;

- The SPC team and staff throughout the hospital were highly motivated and committed to providing holistic, high quality, compassionate care to patients at the end of life and those around them.
- Relationships between staff and patients and their families were strong, caring and supportive.
- Feedback from patients through comment cards during the inspection was 97% positive.
- There were a number of occasions when hospital staff had gone the extra mile. For example, a number of weddings had been facilitated at short notice. This demonstrated a commitment in understanding and responding to the wishes of patients at the end of life.
- We were told that staff supported a patient who was acutely unwell to be present at the birth of their child and arranged for the family to be together at the hospital for the first few important days of family life.
- We saw staff communicating with patients and relatives in a compassionate and respectful manner.
- The privacy and dignity of patients and relatives were maintained consistently.
- We found that patients and relatives were included as partners in their care on a regular basis. Patients and relatives that we spoke to confirmed this.
- Chaplaincy support was available at any time.
- The SPC team had developed an after death communication record and a day after death service that had been implemented to assess the needs of relatives and those close to the patient. It considered a range of needs which included both emotional and

practical support. Families were invited to meet with a designated member of staff following the death of a patient to discuss any additional needs that they might have.

- There was access to medical psychology services who were able to provide support to patients and relatives.
 Staff gave us examples of when this had happened and told us that this service was easy to access.
- Patients belongings were given to family in a handmade canvas bag which were made by volunteers so as to maintain their dignity after death.

Compassionate care

- The SPC team were committed to providing high quality, compassionate care. SPC team members were proud of the type of service that they provided and were keen to maintain high standards of care at all times.
- We saw examples of positive interactions between staff and patients who were at the end of life. Conversations were had in a sensitive and respectful manner. Patients and relatives that we spoke to were keen to tell us that their own experience had been similar.
- We found that the privacy and dignity of patients were respected. Curtains were drawn or doors were closed when patients were receiving care and treatment. Patients who were at the end of life were cared for in private side room. Relatives and those close to the patient were afforded the same level of privacy and dignity.
- Patients and relatives that we spoke to told us that staff had responded in a timely manner if they had required pain relief. We saw when reviewing patient documentation that pain assessments had been completed for patients and if pain relief had been administered, pain scores were reassessed to measure the efficacy of the medication given.
- Staff were able to tell us how they cared for the deceased, ensuring that dignity was maintained after death. A care at and after death document was used which reminded staff to consider trust policy when undertaking last offices. These are the procedures performed shortly after death has been confirmed.

- Porters who were responsible for transferring the deceased from the inpatient wards to the mortuary were employed by another trust. Staff that we spoke to told us that they felt that this was done in a compassionate and dignified way.
- Patient belongings were placed into a handmade cloth bag which was then presented to those close to the patient. The service had developed this as they felt that it gave a personalised touch to the care of the bereaved.
- There was a bereavement policy that was accessible on the intranet. This policy considered special circumstances such as the requirements of different faiths. For example, in some instances, the body of the deceased may have to be released in a more timely manner.

Understanding and involvement of patients and those close to them

- SPC team members and other staff communicated with patients and relatives in a way in which they understood. Patients and relatives that we spoke to confirmed this to be the case.
- Records that we reviewed showed that patients and relatives were involved in their own care and treatment. All treatment options that were available were discussed and patients were given the choice of how they wanted their care to proceed.
- At times when it was uncertain if patients would recover despite treatment being provided, conversations were had so that patients had a choice, for example, what their preferred place of care would be in the event of further deterioration. These discussions were supported by the use of the AMBER care bundle.
- The SPC team had implemented systems such as the rapid discharge plan to support patients in reaching their preferred place of care. However, since January 2016 there had only been one example of this being achieved.
- We were told that staff supported a patient who was acutely unwell to be present at the birth of their child and arranged for the family to be together at the hospital for the first few important days of family life.
- Staff were keen to give us examples of how they had responded to patient's wishes at the end of life. There

were several examples of when staff had facilitated weddings in the hospital, which were often done with a limited amount of time available. On one occasion we saw evidence of a ceremony that had taken place in the Maggies Centre and had been supported by a charity that was based on site. The chaplain had been involved in organising the service and other members of staff had been involved in arranging flowers, rings, music and suits.

Emotional support

- The emotional requirements of patients were considered as part of the individual communication record that was used when it had been recognised that a patient was at the end of life. We reviewed a sample of records and found that there had been a regular reassessment of patient's needs completed which included nutrition, hydration, pain relief, personal hygiene and anxiety on all occasions.
- There was a chaplaincy service that was available to provide emotional support to patients and relatives when needed. The team of chaplains were employed by another trust but were able to respond quickly when required. A chaplain we spoke to was able to give us examples of how support was given and an emphasis was placed on emotional support still being given even if patients and relatives did not have a particular belief.
- The SPC team had developed an after death communication record and a day after death service that had been implemented to assess the needs of relatives and those close to the patient. It considered a range of needs which included both emotional and practical support. Families were invited to meet with a designated member of staff following the death of a patient to discuss any additional needs that they might have.
- There was access to medical psychology services who were able to provide support to patients and relatives.
 Staff gave us examples of when this had happened and told us that this service was easy to access.

Are end of life care services responsive?



We rated end of life care services as 'good ' for responsive because;

- End of life services had been developed to meet the individual needs of patients. The SPC team tried to identify patients and become involved in their care at the earliest possible opportunity.
- The SPC team had met the indicator that a patient's preferred place of care had been discussed on entering the dying phase in 80% of cases.
- The SPC team had developed a day after death service which had been developed to meet the needs of the bereaved after losing a loved one. This service was supported by the care at and after death communication record.
- The service were currently piloting a rapid discharge plan which was used to consider individual needs of the patient and those taking care of them when being discharged to their preferred place of care. Nurses escorted all patients who were on a rapid discharge to promote continuity of care.
- There was a chaplaincy service available which provided emotional support to patients, relatives and also members of staff if required.
- There was overnight accommodation for relatives to use if they wanted to stay with patients at the end of life.

However,

- Staff felt that the viewing room in the mortuary was in a poor state of repair. However, the service encouraged relatives and friends to view the deceased on the inpatient ward as they felt that it was a more suitable environment.
- The rapid discharge plan was currently being piloted, meaning that there had been no measurement of how effective this had been. There had only been one rapid discharge since January 2016.
- There was a trust-wide dementia strategy in place, but this had not yet been adopted for use on the wards.

Service planning and delivery to meet the needs of local people

- Inpatient beds on all wards were available to be used for patients who required palliative care. Each ward had a number of private rooms which had shower and toilet facilities. Staff told us that if a patient required a side room there were not usually any problems in facilitating this. When reviewing a sample of incident reports between April 2015 and March 2016, we only found one occasion when staff had reported that capacity issues had prevented this from happening.
- The SPC team had put systems in place which identified end of life patients at the earliest opportunity. For example, the SPC consultant held two outpatient clinics per week which meant that consideration could be given to strategies such as the AMBER care bundle and gave patients the opportunity to discuss how they would like their care to look as their illness progressed.
- Bereavement support was available for relatives and was provided through an innovative day after death service that the SPC team had introduced. The two key priorities for this service were to ensure that care was right at and after death while also providing any support that relatives or those close to the patient required. The service was used to discuss any practical issues such as the completion of documentation and to explain the involvement of the coroner.
- There was a day after death service which had been designed to meet the individual needs of both the patient and those close to them. This service assessed levels of anxiety or stress, considered the impact of the potential loss of a main financial provider and if the bereaved were able to adequately care for themselves.
- The SPC team had raised concerns about the environment that was available to view the deceased in the mortuary and this was highlighted on the risk register. As a result of this, the service encouraged relatives and friends to view the deceased on the inpatient ward as they felt that it was a more suitable environment. However, we did not see any guidelines detailing how this was facilitated and how long it was before a patient was moved to the mortuary.

Meeting people's individual needs

- Care and treatment was tailored to meet the individual needs of patients who were at the end of life. An individualised communication record had been created and replaced all other documentation once implemented. This document provided continuity of care as any previous information and individual wishes were transferred to the care plan. This information was derived from documents such as the AMBER care bundle or from conversations that had already taken place as part of the advanced care planning process prior to hospital admission.
- The SPC team were piloting a rapid discharge plan to support patients in reaching their preferred place of care when possible. This plan was similar to the Liverpool care pathway but had been adapted sufficiently to meet the needs of individual patients. For example, it considered if relatives had the correct level of care in place to support them in caring for the patient, if the nutritional and hydration requirements had been met and if the appropriate anticipatory medication which included pain relief had been provided.
- A nurse escorted the patient as part of the rapid discharge process to support continuity of care. This included handing over the patient's care plan and any prescribed medication which included syringe drivers if they were being used. However, the SPC team told us that only one rapid discharge had been facilitated since January 2016. This meant that the team had not yet been able to measure the effectiveness of this service.
- The service had access to a number of chaplains who were employed by another trust but were based at the hospital and could be accessed 24 hours a day, 7 days a week. The chaplaincy service met the needs of the most common faiths of patients that used the service. The chaplains also worked closely with leaders of other faiths who could be accessed quickly if needed.
- There was a quiet room available for patients and relatives to use which was located next to the inpatient wards. This was a plain room that had simple resources and could be used for a number of different faiths.
- Inpatient wards had access to two rooms that were used for relatives who wanted to stay overnight. Relatives had access to a small kitchen and shower facilities if needed. There were also fold down bed facilities in each of the rooms used for young people.

- Translation services were available through a telephone line and an interpreter was able to attend the hospital if needed. We found that all advice leaflets and information about the service was provided in English but was available in different languages on request.
- There was a trust-wide strategy for supporting patients with dementia and learning difficulties. However, these strategies had not been introduced to the wards. There was a clinical specialist for additional needs who was available between Monday and Friday in the daytime to support staff if required. Out of hours, each ward had a resource file that included additional documents to support staff in providing appropriate care and treatment to patients with additional needs.

Access and flow

- The SPC team provided support services to both inpatient and outpatient departments of the hospital. There was a referral process available for staff to follow when accessing the SPC team which indicated reasons for referrals to be made. Between April 2015 and March 2016, there had been an estimated 442 inpatient referrals and 93 outpatient referrals. This had increased slightly from the following year.
- Staff told us that there were no problems in accessing a bed if a patient required treatment. The SPC team worked with community based staff and accepted referrals from them when appropriate. The service had three inpatient wards with a total of 74 inpatient beds. This included two step up beds for treating patients who had deteriorated and four beds for young people.
- Records indicated that between March and December 2015, patients had been followed up on 92.6% of occasions within 24 hours. Staff on the inpatient wards told us the SPC team responded in a timely way when a referral was made.
- The SPC team risk assessed and prioritised patients accordingly on a daily basis. If the team were unable to see a patient then telephone support was provided for staff who were providing care. Once a patient was known to the SPC team they had ongoing input into the care and treatment that was delivered.
- Patients preferred place of care was considered and the service was committed to achieving this when practicable. The SPC team had completed an audit

between April 2015 and March 2016 which measured how often a patient's preferred place of care had been achieved. Records indicated that a patient's preferred place of care that had been discussed on entering the dying phase had been achieved in 80% of cases.

• The service had systems in place to facilitate fast track and rapid discharge for patients. A fast track discharge was normally completed within 24 to 48 hours while a rapid discharge was completed in between 3 and 4 hours. However, we found that there was only one example of a fast track discharge being facilitated since January 2016.

Learning from complaints and concerns

- The trust had a clear complaints and concerns policy that was available on the intranet.
- The trust employed a patient advice and liaison service (PALS). This service supported patients and relatives in raising issues that they had.
- During the past 12 months, the palliative care team had not received any formal complaints. Despite this, the PALS officer kept a record of all informal complaints and if there was an issue raised that was associated to the SPC team in any way, the information was shared so that the information could be used for service improvement.
- There were leaflets available throughout the hospital which described the process of making a complaint.

Are end of life care services well-led?

We rated end of life care services as 'good' for well-led because;

- The service had a clear vision and strategy which was supported by an end of life work programme. These included clear indications of delegated responsibilities and time frames.
- There was an up to date risk register for end of life care services. This included all risks that the service currently faced and had clear dates for review.

- The effectiveness of care and treatment that had been provided was monitored through the completion of clinical audits. Members of the SPC team had individual responsibilities when collating this information. The service had developed action plans to implement improvements where required.
- We found a positive and supportive culture which was demonstrated by all staff on inpatient wards as well as members of the SPC team. Results from the NHS staff survey were positive.
- There was evidence of regular engagement with both staff and members of the public. This information was used in developing the services provided.
- The SPC consultant was involved in a number of projects to develop the services not only at the Trust, but also nationally.

However,

- There was limited documented evidence that incidents and complaints were discussed in governance meetings. The management team told us that they had recognised this as an area for improvement.
- End of life services had a service level agreement with another trust for the management of on-site mortuary services. However, this was still under development and we were not assured that the agreement or standards of the mortuary were being monitored on a regular basis.
- A number of standard operating procedures for clinical guidelines such as the use of the individual communication record were still in the process of being developed by the service.

Vision and strategy for this service

- The SPC team had developed a clear vision and strategy which documented areas of the service that they wanted to develop and improve.
- The strategy had been developed against things such as current risks that the service faced, outcomes of audits, and work that had been completed with the Cheshire and Mersey palliative care network. We found that the strategy highlighted all key areas that required improvement and had realistic time frames set for them to be achieved.

- Progress of the strategy was monitored by the end of life lead and the divisional operational manager.
- The vision and strategy was supported by the end of life care work programme that had five key strategic aims. Two examples of this were plans to integrate end of life care services with oncology so that patients who required palliative care intervention could be identified earlier and the team aimed for patients to have equitable access to care which was guided by best practice and was monitored by regular audits.
- Members of the SPC team had ownership of different elements of the work programme. For example, an extra member of staff had been seconded to the team to facilitate advanced care planning and to support staff with the use of the Amber Care Bundle. Also, an SPC nurse had responsibility for developing the education programmes that were being delivered to all hospital staff.

Governance, risk management and quality measurement

- The Director of Nursing had overall responsibility for end of life services at board level. Members of the SPC team told us that they felt supported and that any issues raised were addressed at board level.
- There was a risk register for end of life services. This was up to date and highlighted risks that the service currently faced. Examples of these risks were things such as there not currently being a seven day palliative care service, the inconsistent use of the Amber Care Bundle across the trust and the transfer of the mortuary services in the form of a service level agreement to another trust.
- Each risk had a person assigned for ownership, had last been reviewed in March 2016 and had clear dates for when it was to be reviewed next. Controls were in place to help mitigate the risk that was present and actions included consistent monitoring of the areas that had been identified.
- The end of life care team had undertaken a number of clinical audits that measured the quality of the care and treatment provided. For example, there were regular contributions made to the Cheshire and Mersey palliative care network as well as the National Care of the Dying Audit so that the quality of the service was

continually compared to others both locally and nationally. We found that action plans had been developed as part of these so that improvements were made when needed.

- Governance procedures were reviewed on a regular basis through palliative care team meetings or through divisional meetings that had palliative care representation. The management team told us that topics such as incidents and complaints had been discussed in these meetings. However, we saw limited evidence of these discussions taking place in meeting minutes and the management team told us that this was something that required improvement.
- The trust was in the process of setting up a service level agreement for the mortuary that was on site. We were told that this service had been in place for a number of years. However, we were unsure of how these services were being managed as there were no controls for the trust to monitor if the environment was being maintained appropriately. In addition, it was the responsibility of porters who were employed by a different trust to transfer a patient from the ward to the mortuary, meaning that the service were reliant on them being competent in doing so. A member of the management team had taken the responsibility for putting the necessary controls in place and ensuring that the service level agreement had been signed.
- A number of clinical guidelines had been introduced such as the rapid discharge protocol and the individual care and communication record. These documents provided clear guidance for staff to use when considering what care and treatment to provide for a patient at the end of life. However, there was no evidence of these documents being supported by a standard operating procedure and the management team told us that they were currently being developed.

Leadership of service

• End of life services were led by a consultant in palliative care medicine. The consultant had many years of experience across a range of different services and had been involved in a number of projects to develop end of life services.

- The consultant had been part time up until 12 months ago, having had medical director responsibilities at a nearby hospice. Due to the development of the service, a decision was made to become full time so that more effective leadership could be provided.
- In order to provide high quality services, responsibilities for a variety of projects and the development of different areas of the service had been given to other members of the SPC team.
- There were currently three SPC nurses who supported staff with providing care and treatment throughout the hospital. They also provided education programmes through mandatory training and regular sessions that were open for all staff to attend.
- Staff from the inpatient wards felt that the SPC team were visible, quick to respond and extremely supportive. The SPC team were keen to develop the knowledge and skills of staff throughout the hospital as they saw end of life care being everyone's responsibility.

Culture within the service

- The SPC team were very proud of the work that they were doing. They were focused on providing high quality patient care and meeting the needs of the people that used the service.
- We found there to be an open and honest culture within the service. Members of the SPC team told us that they felt supported in reporting incidents and that there was a no blame culture. On reviewing a number of incident reports, we found a number of examples of relatives being informed if mistakes had been made. The SPC team were keen to learn and make further improvements when required.
- SPC team members provided support to staff throughout the hospital, particularly if they had dealt with a difficult situation. Staff on the inpatient wards were able to give us examples of when members of the SPC team had been supportive in a difficult situation.
- The latest data from the 2015 NHS staff survey showed that 74% of staff would recommend the trust as a place to work and 91% of staff would recommend the trust as a place to be treated.

Public engagement

- The SPC team had completed a quality assurance survey that had measured patient satisfaction with the SPC service in July 2015 which had shown positive results, for example, 89% of people said that there was a sufficient level of nursing care, 100% of people said that they had confidence in the nursing staff and 100% of patients said that staff spent sufficient time in addressing their concerns and giving them information about care and treatment. However, the sample number of this survey was low.
- This information was shared with the Cheshire and Mersey palliative care network and the results were generally better than similar services in the network.
- The SPC team were keen to learn from patient feedback. The day after death service presented an opportunity for the service to listen to what bereaved relatives had to say and this was used as information to inform improvement when required.
- The trust published patient stories as part of their open and honest care programme which was available on their website.Feedback from patients was discussed at board meetings as were patient stories so that improvements could be made to the services provided.

Staff engagement

- The SPC team told us that they felt involved and were able to contribute to developments for end of life services. Staff on the inpatient wards were keen to tell us that the SPC team provided regular support and were available if there were any questions or concerns.
- There were a number of posters advertising training that the SPC team delivered around the hospital. Staff also received email updates with this information.
- The SPC team had developed a quarterly newsletter which discussed any developments, achievements or concerns about the SPC service. The most recent edition had information on topics such as the Amber Care Bundle and advanced care planning.
- The service had engaged student doctors in providing feedback about their placement within the service so that improvements could be made to training if required. Results from this were positive, with the majority of student doctors increasing their knowledge and feeling more comfortable with dealing with patients and their loved ones at the end of life.

• The trust had introduced Schwartz rounds that all staff were able to attend. Schwartz rounds are an evidence based forum for hospital staff to come together to talk about the emotional and social challenges of caring for patients. The aim is to offer staff a safe environment in which to share their stories and offer support to one another.

Innovation, improvement and sustainability

- The service was an active member of the Cheshire and Mersey palliative care network. Network meetings were well attended by different trusts, cancer organisations and hospices from across the two regions. This meant that there were opportunities for organisations to learn from each other and remain up to date with the best evidence based practice.
- The SPC consultant was working in collaboration with care commissioning groups, other cancer organisations and local hospices to develop a more effective lung cancer service. The aim of this project was to prevent the burden of emergency re-admission for patients through the development of more pro-active services. Funding had been agreed so that this project could be undertaken over a two year period.
- The SPC consultant was also involved in developing the serious illness care programme UK which was the first of its kind nationally and was being completed collaboratively with an organisation from the Unites States of America. This programme had been developed in recognition of the difficult conversations that staff have with patients and those close to them at the end of life and the approach had been developed to support clinicians to provide a more structured approach to care and treatment. Funding and support for this was provided by NHS England, will have two initial pioneer sites and is due to begin later in 2016.
- The SPC team had worked collaboratively with a local University to develop a carer's thermometer which was used to continually assess a carer's well-being and their current situation. This had been developed in response to guidance from the National Institute for Health and Care Excellence (NICE) in that carer's needs should be routinely assessed when palliative care and treatment is being provided.

Safe	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Outstanding	公
Responsive	Good	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

A range of outpatient cancer services are provided by The Clatterbridge Cancer Centre NHS Foundation Trust and a number of outpatient appointments are also offered in satellite clinics at hospitals throughout Cheshire, Merseyside and the Isle of Man.

The Clatterbridge Cancer Centre NHS Foundation Trust offers a combination of consultant and nurse-led clinics including clinical and medical oncology and phlebotomy. A number of therapy led appointments are provided including physiotherapy, speech and language therapy and occupational therapy.

Data from the trust showed there were 99,394 outpatient appointments offered across the trust between July 2015 and April 2016 with 43,318 offered at The Clatterbridge Cancer Centre, Wirral.

The diagnostic imaging department sits in the Radiation Service Directorate within the Trust. The department currently consists of two direct radiography (DR) rooms (one of which includes a orthopantomogram (OPT) machine), one computed tomography (CT) scanner, one gamma camera, one positron emission tomography–computed tomography (PET CT) scanner, two magnetic resonance imaging (MRI) scanners, and ultrasound.

We visited The Clatterbridge Cancer Centre NHS Foundation Trust as part of a specialist inspection between the 7 and 9 of June 2016 and performed an unannounced visit on 21 June 2016. We inspected a number of outpatient services including consultant and nurse-led clinics, phlebotomy and therapies.

We spoke with 12 patients and relatives and about 30 staff including in outpatients nursing, medical, allied health professionals, volunteers and managers and in diagnostic imaging the directorate general manager, the medical physics expert, clinical specialist radiographers for each modality as well as a range of radiographers and other support staff within the department.

We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and looked at nine individual care records.

Summary of findings

We rated the service requires improvement because:

- Radiation protection documentation (as required by the Ionising Radiation Regulations 1999 (IRR) and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R)) was overdue for review or did not reflect current clinical practise such as a risk assessment from 2013, and local rules from 2014.
- Staff in diagnostic imaging found it difficult to locate key documents and were not able to demonstrate knowledge or understanding of the contents. Staff found it difficult to access the document control system where these documents were held, and the paper copies in the department were out of date.
- Documentation showed that emergency resuscitation equipment was not consistently checked on the CReST (Cancer Rehabilitation and Support Team) corridor.
- Compliance rates for mandatory and statutory training did not meet the trust targets in a number of subjects.
- Not all staff reported receiving Mental Capacity Act training.
- The outpatient reception and waiting area did not allow privacy and confidentiality when booking in or when height and weight measurements were taken.
- The outpatient waiting area had a limited amount of space and was cramped when clinics were busy.
- There was no defined outpatient physiotherapy service at the time of our inspection, this had been restricted due to the prioritisation of inpatient care.
- The trust consistently failed to meet its target for patients waiting following arrival in the department.
- Staff within the outpatient department reported that morale was not good due to the amount change the department had experienced in a short time period of time and they had not felt involved or consulted with effectively.

However,

- Staff knew how to report incidents and received feedback, lessons learnt were disseminated in monthly team meetings and in the trust wide Team Brief.
- All areas were visibly clean and staff adhered to "bare below the elbow " guidelines.
- Safety testing for equipment was in use across the outpatients department and emergency resuscitation equipment was in place. Medicines were stored securely in a locked cupboard.
- Availability of medical records for outpatients clinic was audited which showed 99% of medical records were available for outpatient clinics.
- Care and treatment within the outpatient department was delivered in line with evidence-based practice and staff provided examples of specific guidance and pathways used.
- Staff meetings took place monthly in outpatients to share information and promote shared learning and an audit programme was in progress assessing compliance in relation to a number of activities.
- Competency assessments were in place for staff in the outpatients department and opportunities were available for continuing professional development including support to attend courses and conferences.
- The outpatients department was staffed by a range of professionals working together as a multi-disciplinary team to provide a comprehensive service to patients and Specialist Nurses were in post in a wide range of specialities.
- Patients were given additional time during consultations particularly when receiving difficult news.
- Between December 2015 and April 2016 results from the NHS Friends and Family Test showed the percentage of patients that would recommend the outpatient service ranged from 94% to 98%.
- Patients and their families were involved in their treatment and care planning.

- Patients received written information regarding their appointment and condition. Car parking, newspapers and refreshments were available free of charge to all patients attending the outpatients department.
- Patients' individual concerns were identified through completion of a Holistic Needs Assessment at varying times during treatment and surveillance and a care plan written to address any identified needs.
- Staff described how people in vulnerable circumstances were accommodated in the department and provided examples of support provided using a multi-disciplinary approach.
- Patients were provided with additional time during their appointment if required and a 24 hour advice line was available for patients with concerns or who felt unwell.
- The trust consistently met the national standard for referral to treatment times for incomplete pathways and for cancer patients to receive first definitive treatment within 31 days of diagnosis.
- The trust DNA rate was consistently lower than the England average.
- The outpatient department was managed within the Chemotherapy Directorate and strategic and operational group meetings took place monthly to discuss risks, performance and key issues. Quality and performance were monitored through a strategic dashboard.
- Staff felt supported by their local managers and said the executive team were visible.
- Daily safety huddles and monthly team meetings took place to ensure staff received information and feedback.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated the service requires improvement because:

- Due to issues surrounding the diagnostic imaging departments leadership and staffing levels, as well as priorities surrounding the installation of the PET-CT scanner, radiation protection documentation (as required by the Ionising Radiation Regulations 1999 (IRR) and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R)) was overdue for review or did not reflect current clinical practise such as a risk assessment from 2013, and local rules from 2014.
- Staff in diagnostic imaging found it difficult to locate key documents and were not able to demonstrate knowledge or understanding of the contents. Staff found it difficult to access the document control system where these documents were held, and the paper copies in the department were out of date.
- Cleaning checklists were not consistently completed in the outpatients department and during periods of peak activity space was limited in the waiting area.
- Documentation showed that emergency resuscitation equipment was not consistently checked on the CReST (Cancer Rehabilitation and Support Team) corridor.
- Compliance rates for mandatory and statutory training did not meet the trust targets in a number of subjects. Completion rates for registered nursing staff in the outpatients team were 80% for Safeguarding Children Level 1 and Safeguarding Adults Level 1 and 50% for Safeguarding Children Level 2 against a trust target of 95%.

However,

- The Trust only directly employed one radiologist for diagnostic imaging; there was a second vacancy, which was being filled by a long-term locum. The Trust had experienced difficulties in recruiting additional radiologists due to a national shortage.
- Planned versus actual staffing numbers reported by the Trust showed that in cross sectional imaging the department was largely understaffed during the day. Rotas ensured that the early, late and on call shifts were

covered to ensure that the department was never left unopen, however day shifts were largely understaffed. During inspection, many of the staff commented on the pressures put on them due to the under staffing. However, at the time of the inspection it appeared there was sufficient staff on the floor at the time to allow for patient safety.

- Staff knew how to report incidents and could give examples of incidents reported. Staff received feedback from incidents and lessons learnt were disseminated in monthly team meetings and in the trust wide Team Brief.
- All areas were visibly clean, staff adhered to " bare below the elbow " guidelines.
- Arrangements were in place for the handling, storage and disposal of clinical waste. Safety testing for equipment was in use across the outpatients department and emergency resuscitation equipment was in place.
- Medicines were stored securely in a locked cupboard and medicine cupboard keys were held in a key safe in the clean utility room which was accessed using a swipe card system.
- Availability of medical records for outpatients clinic was audited which showed 99% of medical records were available for outpatient clinics.
- Staff were able to describe the procedure if a patient became unwell in their department and Emergency Prevention, Preparedness and Response training was incorporated into the trust induction.
- Patient group directives (written instructions for the supply or administration of contrast media by the radiographers) were seen to be up to date.
 Radiographers had also received training enabling them to injection contrast through central lines.
- The Trust has newly installed a programme where internal referrers make all requests for diagnostic imaging examinations electronically. These requests are printed to allow for justification by the radiographers or radiologists and are destroyed confidentially post examination once all information has been inputted into RIS.
- The radiographers were trained to undertake an early warning score on patients they deemed unwell and requiring medical attention, with set pathways in place to provide support and the admitting of outpatients when required.

Incidents

- No serious incidents were reported between April 2015 and March 2016.
- Incidents were reported using a paper based system however plans were in progress to move to an electronic reporting system.
- Staff could describe how to report incidents and reported receiving feedback in monthly team meetings and in the trust wide Team Brief.
- Incidents were discussed at the monthly Chemotherapy Directorate Strategic and Operational Group meetings and information and lessons learnt were disseminated to staff via staff meetings and trust wide email. Staff gave examples of incidents they had reported.
- Staff were aware of the duty of candour and could describe circumstances where it would be used. 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.
- In the past twelve months, the Trust has reported three incidents where patients received a dose 'much greater than intended' reportable to external bodies as per the ionising radiation (medical exposures) regulations 2000 (IR(ME)R). One incident involved a contrast delivery error in CT, where the patient did not receive enough contrast to provide a diagnostic image and therefore the scan required repeating. The second incident involved a failure of images being transferred onto the PACS system from the CT scanner, meaning the patient had to be scanned again. The third involved PET-CT where the scan was repeated as anatomy was missed on the first scan. Where radiation incidents have been reported externally to the relevant bodies, comprehensive root cause analyses have been carried out and action plans formed.

Radiation Protection

• The department utilise a local external radiation protection body through a service level agreement to provide a level B quality assurance programme on the radiation equipment. Within the Trust, there are a

number of physicists that provide medical physics expert support in radiation protection and day-to-day support in nuclear medicine (as per IR(ME)R requirements).

- Three members of the medical physics team are currently working towards their radiation protection advisors (RPA) portfolio. Two other members of the team are already registered as RPAs and support both imaging and radiotherapy. CT and plain film have one radiation protection supervisor to oversee radiation protection, with a second person identified for training in the near future.
- The PET-CT scanner was first commissioned in April 2015 with the first patient scanner in November. The medical physics team and radiographers have worked hard in optimising the doses related to the examinations carried out. The scanner uses a weight based administration system meaning doses to staff, patients and the general public are kept and low as reasonable practicable without comprising on image quality. The average dose recorded by the Trust is 260MBq per patient, much lower than the 400MBz recommendation by The Administration of Radioactive Substances Advisory Committee (ARSAC).
- Due to issues surrounding the departments leadership and staffing levels, as well as priorities surrounding the installation of the PET-CT scanner, radiation protection documentation (as required by the lonising Radiation Regulations 1999 (IRR) and Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R)) was overdue for review or did not reflect current clinical practise such as a risk assessment from 2013, and local rules from 2014.
 When questioning staff, they found it difficult to locate key documents and were not able to demonstrate knowledge or understanding of the contents. Staff found it difficult to access the document control system
- where these documents were held, and the paper copies in the department were out of date.
 In order to address this, the department has contacted
- In order to address this, the department has contacted the learning and development department about adding these to the mandatory training matrix.
- The radiographers stated they act as practitioners under IR(ME)R in justifying examinations for CT and plain film, however despite their experience they are not cited or entitled to do so in the IR(ME)R employers procedures. This again demonstrates shows the poor quality of the radiation protection documentation and a mismatch between documentation and clinical practise.

Cleanliness, infection control and hygiene

- All of the clinical areas we visited were visibly clean and tidy.
- Cleaning checklists were observed in the outpatients department however these were not consistently completed.
- Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare below the elbow" guidelines. Hand gel was readily available in all clinical areas.
- Stickers were placed on equipment to inform staff at a glance that equipment had been cleaned and we saw evidence of this being used across all departments we visited.
- Within the outpatient department curtains were used to screen patients in the consulting rooms and in an area of the waiting room. All curtains were labelled to identify when they had been changed however not all staff were aware of the schedule.
- Arrangements were in place for the handling, storage and disposal of clinical waste. Sharps bins were noted to have been signed and dated when assembled.
- Hand hygiene audit completed between April 2016 and June 2016 indicated that the outpatient department achieved a compliance rate of 94.8% in this period.
- Staff in the outpatients department could describe measures taken when patients attended with suspected communicable diseases including the use of protective equipment, isolating the patient and deep cleaning following the consultation.

Environment and equipment

- The waiting area in the outpatient department was welcoming however during periods of peak activity space was limited.
- A section to one side of the waiting area was also curtained to allow patients to have their height and weight recorded. This reduced the available waiting room space further and limited wheelchair access in that area.
- Safety testing for equipment was in use across the outpatients department and the equipment we reviewed had stickers that indicated testing had been completed and was in date.
- Emergency resuscitation equipment was in place and trolleys we reviewed were checked on a daily schedule. Documentation indicated that emergency equipment in

outpatients department was consistently checked however the resuscitation trolley on the CReST (Cancer Rehabilitation and Support Team) corridor was not documented as checked on 10 occasions between 1st March 2016 and 9th June 2016.

- The diagnostic imaging department currently has poor compliance with equipment quality assurance (QA) particularly in plain film. Manufacturers provide regular servicing and medical physics provide 'level B' tests (IPEM 91) through a service level agreement every two years. 'Level A' tests, which are done in house to monitor equipment performance, were seen to be non-comprehensive and sporadic.
- In plain film, no dark calibration test was recorded to be done between July 2015 and March 2016. There are no records to suggest that tube dose outputs, image quality or automatic exposure chamber cut off consistency is tested in house. This means that there potentially could be a decline in image quality and a rise in patient doses without monitoring.
- This poor compliance has been noted by the medical physics team and there are plans in place to introduce a new QA programme expected July 2016, with new baselines to be set and training for the radiographers.
- The changing rooms each hosted an emergency call bell, and were uncluttered with plenty of space for changing. The changing rooms each backed onto one of the scanning rooms, meaning patients did not have to sit in the waiting areas when changed into gowns.
- There were several resuscitation trolleys throughout the department, including an MRI safe trolley in MRI. There was a rota for checking the resuscitation trolley that was completed daily.
- The diagnostic imaging department has a comprehensive equipment inventory. This included installation and manufacturer dates as required under IR(ME)R.

Medicines

- All medicines in the outpatients department were found to be in date and stored securely in a locked cupboard as appropriate, and in line with legislation.
- No controlled drugs were stored in the outpatients department.
- Prescription pads stored securely and usage tracked.
- Specialist nurses in outpatients were registered nurse prescribers and were supported by a medical mentor.

- Medicine cupboard keys were held in a key safe in the clean utility room which was accessed using a swipe card system.
- The CT contrast media drink was prepared first thing in the morning where possible and kept in a locked cupboard until required.
- There was a contrast warmer in CT to bring the intravenous contrast to body temperature.
- Patient group directives (written instructions for the supply or administration of contrast media by the radiographers) were seen to be up to date.
 Radiographers had also received training enabling them to injection contrast through central lines.

Records

- Three weeks prior to our inspection the trust had introduced an electronic patient record (EPR) however this was used in conjunction with paper medical records to ensure clinicians had full access to previous consultation details.
- Availability of medical records for outpatient clinic was audited and data from the trust showed that 1% of patients are seen in outpatients without the full medical record being available.
- If patient records were unavailable a temporary record was prepared, this meant that clinic appointments were not cancelled due to missing records. Temporary records would include three previous clinic letters, copies of all test results and any correspondence from other clinicians.
- We reviewed nine sets of paper records in the outpatients department. All had dated entries and patient identification on all pages, however five had some entries and signatures that were illegible and three had entries written in blue ink despite one document stating it was to be completed in black ink.
- Radiology records were held securely on the radiology information system (RIS) and patient archiving communication system (PACS). These systems interfaced well and were password protected.
- The Trust has newly installed a programme where internal referrers make all requests for diagnostic imaging examinations electronically. These requests are printed to allow for justification by the radiographers or radiologists and are destroyed confidentially post examination once all information has been inputted into RIS. Even though the system has only been in place for a number of weeks, there are some improvements

the radiographers are planning to make to aid the way the requests are printed out. The CT radiographers have a vision to one day become paperless, where the electronic requests are not printed out. All external referrers still use handwritten requests at the present time.

Safeguarding

- Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- Staff described how they had dealt with safeguarding incidents and how advice had been accessed from the safeguarding team.
- The trust target for completion of safeguarding training was 95%. Data from the trust showed that 100% of administration and clinical services staff from the outpatients team had completed Safeguarding Children Level 1 and Level 2 and Safeguarding Adults Level 1. Completion rates for registered nursing staff in the outpatients team were 80% for Safeguarding Children Level 1 and Safeguarding Adults Level 1 and 50% for Safeguarding Children Level 2.

Mandatory training

- Mandatory and statutory training was available via on-line courses as well as face to face. Mandatory training included subjects such as medicines management and risk management and statutory training included fire safety, health and safety and manual handling.
- The trust target for mandatory and statutory training was 95% however staff in the outpatients department told us that completion of training could be challenging when clinics were busy.
- Data from the trust indicated compliance rates for registered nursing staff ranged from 75% in manual handling and infection control level 2 to 100% in resuscitation and conflict resolution.
- Compliance rates for additional clinical services staff ranged from 75% in basic life support and conflict resolution to 100% for fire safety, health and safety and infection control.
- Administration staff compliance ranged from 50% for fire safety and health and safety to 100% for equality and diversity and infection control.

- However due to low staff numbers across disciplines non-completion by one staff member could impact significantly on compliance rates.
- Radiographers had only reached the Trust's target of 95% completion of mandatory training in 5 out of 15 modules and additional clinical services 12 out of 16.

Assessing and responding to patient risk

- Staff were able to describe the procedure if a patient became unwell in their department including obtaining advice and support from Critical Care Nurses and the Medical Emergency Team (MET).
- If a patient required hospital admission following review and treatment, transfer was arranged either to a ward or by ambulance to the nearest accident and emergency department depending on the nature of the patients' illness.
- Each modality had a morning safety huddle where all staff attended to discuss the upcoming day in terms of staffing, scheduled patients, departmental information and equipment performance. Staff were updated on safety issues for the upcoming shift and any potential risks to patients were discussed, such as patients requiring additional scanning time, and patients attending who may have similar names.
- All patients from the upcoming day were either checked the night before or first thing in the morning to ensure that all previous imaging was noted, justification had been carried out, the protocols were available, and that the blood test results were up to date. Having this information in advance meant that the patient pathway was smooth, and ensured that the patient was not waiting for this information to be checked.
- The radiographers were trained to undertake an early warning score on patients they deemed unwell and requiring medical attention, with set pathways in place to provide support and the admitting of outpatients when required.

Nursing staffing

- Outpatient clinics were staffed by a combination of specialist and outpatient nurses.
- The outpatient nursing structure had undergone a change in skill mix and role prior to our inspection. Nursing staff were split into teams led by a staff nurse supported by health care assistants and support workers.

- The new structure was to support an increase in workload due in part to due to reallocation of clinics from the day case ward to the outpatients department.
- This was identified as a risk within the department and recruitment was in progress during our inspection.
- Outpatient nurse staffing was planned in advance to manage the work load and a deputy manager and a Matron were in post.

Radiology staffing

- The diagnostic imaging department had three vacancies in cross-sectional imaging (CT and MRI) which were being filled by agency members of staff. One of the agency radiographers had accepted a permanent post within the Trust; however they were currently out to advert for another three radiographers. Nuclear medicine had two vacancies currently filled with agency staff.
- Planned versus actual staffing numbers reported by the Trust showed that in cross sectional imaging the department was largely understaffed during the day. Rotas ensured that the early, late and on call shifts were covered to ensure that the department was never left unopen, however day shifts were largely understaffed. During inspection, many of the staff commented on the pressures put on them due to the under staffing. However, at the time of the inspection it appeared there was sufficient staff on the floor at the time to allow for patient safety.
- All radiographers were band 6 or above, meaning there was a lot of experience within the teams.
- The Trust had Radiology assistants working in each modality. These assistants had had the opportunity to learn to cannulate patients to assist with a streamlined patient pathway within the department.

Allied Health Professionals

- Physiotherapists, occupational therapists, speech and language therapists and dieticians were part of the Cancer Rehabilitation Support Team (CReST).
- Staff told us that there was no defined outpatient therapy service and at the time of our inspection the outpatient physiotherapy service was restricted due to the prioritisation of inpatient care. This was confirmed by management and recorded on the Integrated Care Directorate Risk Register.

Medical staffing

- There was a sufficient number of medical staff to support outpatient services. We found that the majority of clinics were covered by consultants supported by registrars.
- The Trust only directly employed one radiologist for diagnostic imaging; there was a second vacancy, which was being filled by a long-term locum. The Trust had experienced difficulties in recruiting additional radiologists due to a national shortage. The Trust had a service level agreement with two local Trusts to provide sessional input from other consultants; however the Trust listed this lack of direct hire radiologists as one of the highest risks on their risk register.
- The Trust had identified the risk posed from the use of locum radiologists; these included a potential reduction in reporting quality and financial implications for the Trust. In not having a single pool of specialist cancer imaging radiologists meant there was limited support with multi-disciplinary team (MDT) meetings and limited expertise in the Trust's specialist fields.
- There was also an impact on the radiographers as there was limited support in professional development such as plain film reporting and other extended roles.

Major incident awareness and training

- The trust had a major incident policy which listed key risks that could affect the provision of care and treatment.
- Most staff members were aware of the policy and how to locate it on the trusts intranet.
- Emergency Prevention, Preparedness and Response training was incorporated into induction training when new staff commenced employment with the trust.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate effective for outpatients however we found that:

• Care and treatment within the outpatient department was delivered in line with evidence-based practice and staff provided examples of specific guidance and pathways used.

- Staff meetings took place monthly in outpatients to share information and promote shared learning and an audit programme was in progress assessing compliance in relation to a number of activities.
- Analgesia could be prescribed for individual patients in the outpatients department and refreshments were available for patients who were waiting, including provision of packed lunches if required.
- Competency assessments were in place for staff in the outpatients department and opportunities were available for continuing professional development including support to attend courses and conferences.
- Managers described how they managed poor performance including provision of support, regular 1:1 meetings and additional training.
- The outpatients department was staffed by a range of professionals working together as a multi-disciplinary team to provide a comprehensive service to patients and Specialist Nurses were in post in a wide range of specialities.
- A one stop clinic was available for patients with brain cancer. This allowed patients to attend for scans, blood tests and consultation in one visit and prevented the need to return for several appointments.
- The CT radiographers regularly reviewed images for unexpected or significant findings. They stated pick up rate for pulmonary embolisms was high, however there was no data to support this as it has not been audited. Due to this early image review, patients were able to be treated much quicker, and any patient not due to be seen the same day elsewhere in the hospital, were able to receive treatment on the day if any significant pathology needed urgent treatment.
- The radiographers were trained to undertake an early warning score assessments on patients they deem unwell and require medical attention, with set pathways in place involving a medical registrar able to provide support and the admitting of outpatients when required.
- There was a robust system in place involving the research radiographer, to identify new research trials involving ionising radiation and systems were in place to ensure that the timings of the research protocols of scans were followed.

• A range of training records for CT radiographers were observed. These records encompassed the equipment competencies. The training records were not up to date to reflect new techniques or equipment updates. One of the records was first completed in 2011 and another 2010 with no updates since.

Evidence-based care and treatment

- Care and treatment within the outpatient department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Staff described the use of guidelines from the United Kingdom Oncology Nursing Society (UKONS), pathways for sepsis for patients receiving chemotherapy and palliative care and NICE protocols for the treatment of breast cancer patients with lymphoedema.
- Clinical Nurse Specialists for head and neck cancers used an algorithm for pain control.
- Staff meetings took place monthly in outpatients to share information and promote shared learning.
- Policies and procedures were in place and could be accessed via the trust's intranet, and staff were aware of how to access them.
- An audit programme was in progress assessing compliance in relation to a number of activities including patients receiving appointments with a specialist nurse within three months of referral, consent and infection control.
- With the introduction of the PET-CT service in November 2015, there was good evidence that patients would benefit from improved disease assessment resulting in altered management and improved outcomes in line with the Royal College of Radiologists (RCR) guidance.
- National Diagnostic Reference Levels (DRLs) are dose levels set by Public Health England and are intended to promote awareness, dose audit and comparison as the basis for improving patient radiation protection, with an implied maintenance of diagnostic quality. National levels had been adopted by the Trust and these were displayed at the CT console.
- There were plans in place to establish local levels (LDRLs) through dose audits in the near future by medical physics team to better reflect local workload.

However,

• There was a robust system in place involving the research radiographer, to identify new research trials involving ionising radiation and systems were in place to ensure that the timings of the research protocols of scans were followed.

Pain relief

• Analgesia could be prescribed for individual patients in the out patients department using 'Take Home' prescription or an inpatient prescription for a once only dose.

Nutrition and hydration

- A water fountain was available in the outpatient waiting area and hot drinks were offered by volunteers to patients waiting to see a clinician.
- Packed lunches were provided to patients who were waiting for their appointment over lunch time.

Patient outcomes

- The trust rate of follow up appointments in relation to new appointments was consistently higher than the England average between January 2015 and December 2015 however this is attributed to the nature of the trusts' speciality.
- The trust was involved in national benchmarking. This allowed services to identify best practice and continuously improve by comparing performance with other similar services.
- Staff described their involvement in Clinical Network and Site Reference Groups.
- Site Reference Groups were set up for every tumour group and met every three months. This was a multi-disciplinary meeting to review specific treatments, national guidance, policies, procedures research, audit and patient experience to ensure best practice.
- The trust had a wide portfolio of research and was involved in both treatment and data trials.
- The trust were part of the Merseyside and Cheshire Cancer Research Network.
- The imaging department had an audit schedule where all modalities were audited for compliance against patient identification and checking of pregnancy as well as other audits including accuracy of radiographers reports for intra orbit foreign body x-rays, and access to imaging. This had historically been the responsibility of one person. This person had recently resigned from this role as they had struggled to action any

non-compliances due to lack of managerial support within the department and lack of dedicated time due to staff shortages. The audit lead found that during an extended period of sickness no audits were carried out to support her.

 The CT radiographers regularly reviewed images for unexpected or significant findings. They stated pick up rate for pulmonary embolisms was high, however there was no data to support this as it has not been audited. Due to this early image review, patients were able to be treated much quicker, and any patient not due to be seen the same day elsewhere in the hospital, was able to receive treatment on the day if any significant pathology needed urgent treatment. The radiographers were trained to undertake an early warning score assessments on patients they deem unwell and require medical attention, with set pathways in place involving a medical registrar able to provide support and the admitting of outpatients when required.

Competent staff

- Competency assessments were in place for outpatient staff and induction processes were in place for new staff. We saw documentation to support this which included medical devices, venepuncture and oral chemotherapy administration and provision.
- Staff told us that opportunities were available for continuing professional development including support to attend courses and conferences.
- Staff identified their training needs through the trusts annual appraisal process and the trust target was 95%.
- Data from the trust indicated the appraisal rate for the outpatients team was 100% for administration and clerical staff, 100% for additional clinical services staff and 75% for registered nursing staff however three out of the four outpatient nurses had received an appraisal.
- Managers described how they managed poor performance including provision of support, regular 1:1 meetings and additional training.
- All radiographers were band 6 or above, meaning there was a wealth of experience within the department.
- A range of training records for CT radiographers were observed. These records encompassed the equipment competencies. The training records were not up to date to reflect new techniques or equipment updates. One of the records was first completed in 2011 and another 2010 with no updates since.

- CT staff had been trained to administer IV contrast through Hickman lines.
- There was little evidence of access to Continuing Professional Development for the radiographer, however we were told that all reasonable requests were considered, however the radiographers had to be proactive in asking for these.

Multidisciplinary working

- The outpatients department was staffed by a range of professionals working together as a multi-disciplinary team to provide a comprehensive service to patients.
- Specialist nurses were in post and provided a wide range of nurse-led clinics covering a range of specialities including lung cancer, prostate cancer, breast cancer, gynaecology and urology.
- The Cancer Rehabilitation Support Team (CReST) consisted of clinical nurse specialists, physiotherapists, occupational therapists, dieticians and a social worker. All disciplines were based on the CReST corridor which allowed for informal multi-disciplinary discussion as well as more formal multi-disciplinary meetings. Professionals provided examples of how this arrangement had enhanced the care provided to patients.
- A one stop clinic was available for patients with brain cancer. This allowed patients to attend for scans, blood tests and consultation in one visit and prevented the need to return for several appointments.
- Medical staff dictated the outcome of consultations following patient attendance and letters were sent from the outpatients department to patients' GPs to provide a summary.

Seven-day services

- There were no weekend clinic appointments offered in the outpatients department.
- The imaging department only operated Monday to Friday during the day, with an on call plain film service during the evenings, nights and weekends. There were no requirements in the capacity to offer seven-day services in CT, ultrasound or MRI.

Access to information

• Data from the trust showed availability of medical records for outpatient clinics was 99%.

- Medical staff had access to an electronic tablet to document patient details. This ensured patient information was available in peripheral clinics.
- Staff were able to access information such as policies and procedures from the trust's intranet.
- Staff Trust wide had access to radiology images through the PACS (picture archiving and communication system).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients worked on the principle of implied consent.
- If written consent was required for more complex procedures this was obtained by consultants.
- Nursing staff described the consent forms within the department and the circumstances for use.
- Nursing staff supported consultants with the consent procedure by providing time and opportunity to ask additional questions.
- Mental Capacity Act training was included within safeguarding training and staff had received pocket sized guides to assist with Safeguarding Adults in clinical practice.
- Information about mental capacity act, and deprivation of liberties was displayed around the department. Other posters regarding bereavement, chaplain, and counselling were also displayed.

Are outpatient and diagnostic imaging services caring?

Outstanding

1

We rated the service outstanding because:

- Every patient had a Holistic Needs Assessment completed as part of their diagnosis. This included questions regarding spiritual and psychological needs and emotional health as well as practical and physical concerns. A care plan was then written to address any issues identified.
- Further assessment of holistic needs was completed during treatment and surveillance to identify evolving and changing needs.
- Patients were given additional time during consultations particularly when receiving difficult news.

- Staff demonstrated commitment within the outpatients department and would stay beyond the end of their shift when clinics finished late to ensure patients were supported and cared for.
- We spoke with patients and families who told us they had experienced "nothing but kindness", that staff had been "lovely" and they had time to ask questions.
- Between December 2015 and April 2016 results from the NHS Friends and Family Test showed the percentage of patients that would recommend the outpatient service ranged from 94% to 98%. In the last 4 months of the financial year 95% of respondents to Friends and Family Test (a patient satisfaction questionnaire) in diagnostic imaging would recommend this service. These results are displayed in the waiting area.
- The trust had clinical nurse specialists available for patients to talk to about their condition and patients and carers who required psychological support were referred to the Psychological Medicine service.
- Patients and their families were involved in their treatment and care planning. Radiology assistants chaperoned all ultrasound examinations. Confidentiality was observed at all times.
- Volunteers provided free refreshments to patients and visitors in the outpatient department.
- Reception and nursing staff were polite and helpful and treated patients and their families with respect.
- One patient spoke highly of the radiology department, mentioning its efficient, caring and supportive staff.
- Staff were compassionate to patients, explaining that they regularly experience patient breakdowns due to the nature of their diagnoses. Staff were able to dedicate time to these patients and had developed skills to allow staff to show compassion and supportive attitudes.
- There are a low amount of MRI claustrophobic failures as staff were able to support patients through the examinations.

However,

• The reception and waiting area in the outpatients department did not allow privacy and confidentiality when booking in or when height and weight measurements were taken.

Compassionate care

• We witnessed reception and nursing staff being polite and helpful and introducing themselves by name.

- All staff were observed wearing name badges as part of the "Hello, my name is" initiative within the trust.
- The trust had a Chaperone policy in place. Staff could discuss its application and could locate it on the intranet. Radiology assistants chaperoned all ultrasound examinations. Confidentiality was observed at all times.
- Staff described how patients were given additional time during consultations particularly when receiving difficult news.
- We spoke with patients and families who told us they had experienced "nothing but kindness", that staff were very helpful and how the department "had a nice atmosphere".
- Volunteers provided free refreshments to patients and visitors in the outpatient department.
- Patient satisfaction surveys were conducted monthly and had resulted in an action plan to address some of the issues raised including a review of the work force and implementation of team working to improve clinic waiting times.
- Staff demonstrated commitment within the outpatients department and would stay beyond the end of their shift when clinics finished late to ensure patients were supported and cared for.
- Staff were compassionate to patients, explaining that they regularly experience patient breakdowns due to the nature of their diagnoses. Staff were able to dedicate time to these patients and had developed skills to allow staff to show compassion and supportive attitudes.
- The NHS Friends and Family Test, which assesses whether patients would recommend a service to their friends and family showed that between December 2015 and April 2016 the percentage of patients that would recommend the outpatient service ranged from 94% to 98%. In the last 4 months of the financial year 95% of respondents to Friends and Family in diagnostic imaging would recommend this service. These results are displayed in the waiting area.

Understanding and involvement of patients and those close to them

• Most patients reported receiving their next appointment before leaving the outpatients department and were provided with a contact number to call in between consultations if required.

• Four out of five patients reported receiving copies of GP letters following their consultation however leaflets were available near the outpatient department advising patients how to request this.

Emotional support

- The trust had clinical nurse specialists available for patients to talk to about their condition and patients or carers with complex issues were referred to the Psychological Medicine service.
- The Psychological Medicine service comprised of psychiatrists and a counsellor and the service was also available as a resource for other clinicians.
- Patients told us they and their families were involved in their treatment and care planning, they had time to ask questions and they received care in all areas including finances.
- Every patient had a Holistic Needs Assessment completed as part of their diagnosis. This included questions regarding spiritual and psychological needs and emotional health as well as practical and physical concerns. A care plan was then written to address any issues identified.
- Further assessment of holistic needs was completed during treatment and surveillance to identify evolving and changing needs.
- Patients told us they had received information leaflets regarding their condition and a variety of literature was available from the Macmillan Cancer Information and Support Centre located in the main hospital reception.
- There are a low amount of MRI claustrophobic failures as staff are able to support patients through the examinations.

Are outpatient and diagnostic imaging services responsive?

Good

We rated the service good because:

• Patients received written information regarding their appointment and condition. Car parking, newspapers and refreshments were available free of charge to all patients attending the outpatient department.

- Patients' individual concerns were identified through completion of a Holistic Needs Assessment at varying times during treatment and surveillance and a care plan written to address any identified needs.
- Pagers were available to allow service users to leave the waiting area and be recalled when it was time for their consultation.
- Staff described how people in vulnerable circumstances were accommodated in the department and provided examples of support provided using a multi-disciplinary approach.
- An initiative was being rolled out to enhance the patient experience by telephoning patients prior to their appointment to obtain specific information for the individual patient and identify any reasonable adjustments they may require to support their attendance.
- Patients were provided with additional time during their appointment if required and a 24 hour advice line was available for patients with concerns or who felt unwell.
- The trust consistently met the national standard for referral to treatment times for incomplete pathways and for cancer patients to receive first definitive treatment within 31 days of diagnosis.
- The trust DNA rate was consistently lower than the England average and the annual trust target of 4%.
- Staff we spoke with knew how to sign post patients to PALS (Patient Advice and Liaison Service).
- The Trust had targets for the clinical evaluation of imaging produced by the radiologists for all imaging to be in two days. The Trust had experienced reporting capacity issues due to the way the radiologists were structured. To help mitigate this risk, the Trust used an external reporting consortium for all muscular-skeletal imaging and an outsourcing company when they struggled to reach their reporting targets.
- At the time of the inspection, there is a single radiographer who provided reporting support to aid research measurements of tumour growth/remission as part of the Response Evaluation Criteria In Solid Tumours (RECIST) measurements.

However,

- The outpatient waiting area had a limited amount of space and was cramped when clinics were busy.
- There was no defined outpatient physiotherapy service at the time of our inspection, this had been restricted due to the prioritisation of inpatient care.

• The trust consistently failed to meet its target for patients waiting following arrival in the department; however patients were added to clinics at short notice if their condition required an appointment be brought forward.

Service planning and delivery to meet the needs of local people

- We observed clear signposting through the hospital to the outpatients department.
- Patients received information with their appointment letters regarding transport and parking and car parking was available at no charge. Transport was available for patients if required however this was arranged by the patients GP.
- Patients told us they were given written information as needed.
- The outpatient waiting area had a limited amount of space and was cramped when clinics were busy. The reception area was open to the waiting room and patients were overheard booking in and conversing with clerical staff at the reception desk. An area of the waiting room was curtained off to allow patients to have their height and weight recorded. Although patients were not visible this arrangement did not afford privacy or confidentiality.
- Toilets and a water fountain were accessible in the waiting area and volunteers offered hot drinks to patients waiting for their appointment.
- Free newspapers and magazines were available and packed lunches were provided to patients waiting over lunchtime.
- Pagers were available to allow service users to leave the waiting area and be recalled when it was time for their consultation.
- The imaging department underutilised an MRI scanner following the withdrawal of a contract with a local NHS Trust. This scanner was 14 years old, however its replacement was currently dependant on the capacity being filled through other external contracts with other local Trusts. This meant that the scanner was left unoccupied for 3 days during each week. The Trust did not have the radiographer capacity or patient capacity to increase the usage. However, local patient needs were being met.
- The medical physics team were currently working towards the radiation protection advisors portfolio and

had plans in the near future to register as an RPA body, to provide all medical physics services in house, rather than rely on a service level agreement with another body which they were currently doing.

• The Trust had one radiographer that provided a Doppler ultrasound service in the Trust. Currently when they were away, patients had to be seen at another local Trust; however there were plans in place to train a second radiographer to provide a more consistent service.

Meeting people's individual needs

- A palliative care pathway was in place for pain management and symptom control. Staff described how patients who attended clinic requiring urgent assessment had been seen immediately.
- Individual needs of patients were identified through completion of a Holistic Needs Assessment at varying times during treatment and surveillance. Following completion a care plan was formulated to summarise any concerns and identify actions to address them.
- Staff described how people in vulnerable circumstances were accommodated in the department and how their appointment could be escalated if required.
- At the time of our inspection seven of the 11 staff in the outpatients department had attended dementia awareness training and three more staff were scheduled to attend.
- Staff provided several examples of the involvement of the Clinical Specialist for Additional Needs when patients had attended the hospital and the multi-disciplinary approach taken to provide support.
- Access to interpreting services could be arranged for those patients who did not speak English and staff told us this was always with a face to face interpreter, however we did not see this in use during our inspection.
- Staff told us that there was no defined outpatient physiotherapy service at the time of our inspection, this had been restricted due to the prioritisation of inpatient care. This was confirmed by management and recorded on the Integrated Care Directorate Risk Register.
- A one stop clinic was available for patients with brain cancer. This allowed patients to attend for scans, blood tests and consultation in one visit and prevented the need to return for several appointments.
- The trust had piloted an enhanced calls project between August 2015 and November 2015 which
involved telephoning patients prior to their appointment. The aim was to enhance the patient experience by providing specific information for the individual patient, identify any reasonable adjustments they may require to support their attendance and confirm their details. While supporting the patients experience the project also aimed to reduce non-attendance for appointments. Patient response was very positive and recruitment was in place at the time of inspection to implement the initiative.

- First appointments for new service users were scheduled for 45 minutes however staff told us that if patients required more time this was accommodated.
- Follow up appointments were given to most patients before they left the department and a 24 hour advice line was available for patients with concerns or felt unwell.

Access and flow

- The trust met the national standard of 92% for referral to treatment rates each month for incomplete pathways between April 2015 and March 2016. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.
- No data was reported against the referral pathway standard for cancer patients to be seen by a specialist within two weeks of urgent GP referral.
- The trust consistently met the target for 96% of cancer patients to receive first definitive treatment within 31 days of diagnosis between Q3 2014-15 and Q3 2015-16.
- The trust adheres to the locally agreed Cheshire and Merseyside post reallocation measure for patients to wait less than 62 days from urgent GP referral to starting treatment. This specifically takes effect when the trust receives a patient from another provider after day 42 of the pathway. When this measure was applied the trust met the target and the England average on a consistent basis between Q4 2013-14 and Q3 2015-16.
- Between April 2015 and February 2016 5.3% of appointments were hospital cancelled. The main reason for cancelled clinics over six weeks was consultant sickness.
- Patients and staff told us that some clinics run late and display boards were in operation to advise patients of delays as well as verbal notification provided by staff.
- The outpatient waiting time target was 80% of patients waiting less than 30 minutes to be seen. Data from the trust showed between Q1 and Q3 2015-16 the

percentage of patients seen within 30 minutes ranged from 68.1% to 70.9%. The most recent figures available at the time of inspection showed 72.2% of patients were seen within 30 minutes in April 2016.

- Consistently failing to meet the waiting time target was recorded as a risk on the outpatient department risk register. However staff told us that patients were added to clinics at short notice if their condition required an appointment be brought forward and patients told us they had time in consultations to ask questions.
- The trust had a number of patients who failed to attend for their appointments (DNA) however, the trust DNA rate was consistently lower than the England average and between June 2015 and March 2016 was consistently below the annual trust target of 4%.
- Plain film examinations were performed on a walk in basis between 0900-1700hrs on weekdays. Outside of these hours, plain film provide out of hours cover for x-rays for inpatients.
- CT operated 0845-1715hrs Monday to Friday, however the department is looking to extend these hours from 0800-1800, but are restricted due to staffing levels.
- MRI operated 0800-1715hrs Monday, 0800-2000hrs Tuesday, Wednesday and Thursday and 0800-1700hrs Friday. With a second scanner only in use 0900-1700hrs Tuesday and Thursday. MRI GP direct access had dedicated schedules 0800-0900hrs on weekdays and 1700-2000hrs Tuesday, Wednesday and Thursday. Scans requiring contrast were scheduled during the day when there was radiologist support.
- The CT and MRI largely had pre-booked appointments for their patients; however they did have appointment slots available to non-pre-booked patients, which were generally filled depending on need for inpatients or patients attending triage or clinics. Scheduling in CT allowed for inpatients to be scanned the same day as the request in most cases, also allowing for some walk in patients following triage. This was due to the 30 minute slots over the lunch and late afternoon appointments.
- The Trust had reported only one breach of the 6 week wait target for an imaging appointment in the period April 2015 to February 2016.
- Justification of examinations was carried out by radiographers in CT and plain film. This meant that patients were not delayed awaiting appointments to be scheduled due to vetting.

- The department regularly audit waiting times for patients once they had arrived in the department for CT, MRI, NM and PET-CT. In a recent audit, MRI had noted that only 78% of patients are seen within 30 minutes of their appointment time, with 9.4% waiting over an hour. Analysis of these times had meant that trends had been detected. These included delays in hospital transport, and multiple appointments within the Trust (including other diagnostic tests and planning scans done in radiotherapy).
- The Trusts targets for the clinical evaluation of imaging produced by the radiologists for all imaging to be in two days. The Trust had experienced reporting capacity issues due to the way the radiologists were structured. To help mitigate this risk, the Trust used an external reporting consortium for all muscular-skeletal imaging and an outsourcing company when they struggled to reach their reporting targets.
- At the time of the inspection, there is a single radiographer who provided reporting support to aid research measurements of tumour growth/remission as part of the Response Evaluation Criteria In Solid Tumours(RECIST) measurements.

Learning from complaints and concerns

- Initial complaints were dealt with by managers in the outpatients department however if this was unsuccessful information was provided about the patient advice and liaison service (PALS).
- Staff we spoke with knew how to sign post patients to PALS and information for patients about comments, concerns or complaints was observed on the notice board at the entrance to the outpatients department. Patients told us they would know how to make a complaint if needed.
- The trust had a complaints policy and in the period 2015-16 15 complaints were received relating to the outpatients department. Of the complaints reviewed five related to communication and one to waiting times.
- There had been no formal complaints made to diagnostic imaging in the past twelve months.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated the service requires improvement because:

- Staff reported that morale in the outpatients department was not good due to the amount of change the department had experienced in a short period of time. Staff told us they had not felt involved or consulted with effectively.
- Managers acknowledged there had been significant changes and challenges including staffing, workload and the introduction of the Electronic Patient Record.
- With exception to the Transforming Cancer Care strategy, there was little vision within the diagnostic imaging team. This was due to a long standing vacancy in the professional lead of the department.
- Governance support for the diagnostic imaging department was provided by one person who also covered radiotherapy. It was sometimes difficult to access them as they were overstretched with the two departments. This was clear from the issues in radiation protection surrounding the department. These gaps had been identified by a member of staff that started in November and escalated to management level, however due to the staff shortages and lack of professional leadership within the department, little support has been made available to rectify these concerns.
- The Trust had on going difficulty in recruiting and retaining staff in the professional lead post in radiology. There were also vacancies in the modality lead posts, with PET/CT and nuclear medicine being the only speciality with a filled position. This meant there was a disconnect between the department staff and the top of the directorate.
- There were also a number of vacancies in the medical physics team. This had meant much of the radiation protection and safety aspects within the Trust had been neglected with much documentation overdue for review. This was due to a recent restructure of the medical physics team following the previous RPA retirement. The Trust had recently offered these positions to experienced physicists and was awaiting their start.

However,

- The outpatient department was managed within the Chemotherapy Directorate and strategic and operational group meetings took place monthly to discuss risks, performance and key issues. Quality and performance were monitored through a strategic dashboard.
- Staff felt supported by their local managers and said the executive team were visible.
- There was an open and honest culture within the service and staff were candid about the challenges they faced.
- Daily safety huddles and monthly team meetings took place to ensure staff received information and feedback.
- Physical and psychological support services were available to staff and staff were aware of how to access them

Vision and strategy for this service

- The trust vision was "To provide the best cancer care to the people we serve". Staff were aware of the vision and could describe the values which included "achieving excellence" and "being passionate about what we do".
- Each Directorate had Directorate and Service Delivery Plans. The chemotherapy services directorate plan included tasks such as the sustainable delivery of safe and effective out-patient services and engaging departmental staff in the design and planning of new services.
- Plans were in progress for relocation of the hospital to a new site as part of the five year Transforming Cancer Care Strategy.
- The outpatient department was led by a Matron supported by a deputy manager.
- Staff told us that managers, clinical leads and the executive team were visible.
- With exception to the Transforming Cancer Care strategy, there was little vision within the diagnostic imaging team. This was due to a long standing vacancy in the professional lead of the department.
- The medical physics team currently had three people working towards their RPA portfolios and there was a plan in place to apply to be an RPA body to provide more services from in house.

Governance, risk management and quality measurement

- The outpatient department was managed within the Chemotherapy Directorate and strategic and operational group meetings took place monthly to discuss risks, performance and key issues.
- Quality and performance were monitored through a strategic dashboard and included data regarding referral to treatment times, non-attendance and waiting times following arrival in the department.
- The departmental risk register encompassed a range of risks to the department. A common theme was the increasing issues with capacity and the age of some equipment.
- Governance support for the department was provided by one person who also covered radiotherapy. Staff had mentioned that it was sometimes difficult to access them as they were overstretched with the two departments. This was clear from the issues in radiation protection surrounding the department. These gaps had been identified by a member of staff that started in November and escalated to management level, however due to the staff shortages and lack of professional leadership within the department, little support has been made available to rectify these non-compliances

Leadership of service

- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.
- Following implementation of a new approach to staff planning the deputy manager was designated as supernumerary to act as the service co-ordinator however records showed she was required to work clinically on nine occasions between 03/05/16 and 03/ 06/16.
- Staff felt supported by their local managers and said the executive team were visible.
- Daily safety huddles and monthly team meetings took place to ensure staff received information and feedback.
- Staff received a Team Brief and weekly E-bulletin which provided updates from within the trust.
- The Trust had on going difficulty in recruiting and retaining staff in the professional lead post. There were also vacancies in the modality lead posts, with PET/CT and nuclear medicine being the only speciality with a filled position. This meant there was a disconnect between the department staff and the top of the directorate.

- There were also a number of vacancies in the medical physics team. This had meant much of the radiation protection and safety aspects within the Trust had been neglected with much documentation overdue for review. This was due to a recent restructure of the medical physics team following the previous RPA retirement. The Trust had recently offered these positions to experienced physicists and was awaiting their start.
- On talking to many of the radiographers, it was unclear what their lines of accountability were and how to escalate issues beyond the clinical specialists for each modality.

Culture within the service

- There was an open and honest culture within the service and staff were candid about the challenges they faced.
- We observed good team working within the outpatients department however staff reported that morale was not good due to the amount change the department had experienced in a short time period of time.
- Managers acknowledged there had been significant changes and challenges including staffing, workload and the introduction of the Electronic Patient Record.

Public engagement

- The views of patients were actively sought within the outpatient department using the NHS Friends and Family Test and patient satisfaction surveys.
- A patient questionnaire had been used in February 2016 to obtain patient opinion about the chairs used in the outpatient department.

Staff engagement

- Staff told us they had not felt involved or consulted with effectively regarding some of the recent changes to the department.
- Results of the 2015 NHS Staff Survey showed the trust scored higher than the national average for acute

specialist trusts for staff recommending the organisation as a place to work or receive treatment and staff motivation at work. However the trust scored lower than the national average for staff satisfaction with resourcing and support.

- Schwartz rounds took place which staff spoke positively about. Schwartz rounds are a structured forum where staff from all backgrounds meet in a confidential environment to discuss the emotional and social challenges of caring for patients.
- A staff awards system was in process to recognise individual achievements. Nominations could be made by staff, patients or families and a notice within the outpatient department indicated that a member of the nursing staff had recently been nominated for an award.
- Physical and psychological support services were available to staff and staff were aware of how to access them.

Innovation, improvement and sustainability

- A wide portfolio of research was undertaken by the trust including involvement in both treatment and data trials. Examples included STAMPEDE in relation to prostate cancer and PACMEL for patients with melanoma.
- A Care Navigator role had been introduced to provide guidance and support to patients by referral or signposting to information, specialist services or Clinical Nurse Specialists.
- An enhanced calls service was in operation to improve the patient experience. This entailed telephone contact with the patient prior to their appointment to provide specific information, identify any reasonable adjustments that may be required and support their attendance.
- Completion of the patient experience survey had begun to be collected by hand held tablet during our inspection. Patients were supported with this process by volunteers in the outpatient waiting area.

Safe	Good	
Effective	Good	
Caring	Outstanding	\Diamond
Responsive	Outstanding	\Diamond
Well-led	Outstanding	\Diamond
Overall	Outstanding	

Information about the service

Chemotherapy services are provided by The Clatterbridge Cancer Centre's Trust's Systematic Anti-Cancer Therapy (SACT) Service. This service is provided at the Clatterbridge Cancer Centre and at eight peripheral satellite clinics at a range of locations, which include acute general hospitals, primary care centres and other sites managed by the trust. The service also provides certain types of chemotherapy in patient's homes. This service is provided by staff employed and trained by the Clatterbridge Cancer Centre.

The adult day-case Delamere chemotherapy unit is located at the Clatterbridge Cancer Centre. This unit is open Monday to Friday between the hours of 8.30am and 6.30pm.

Between April 2015 and April 2016, the unit delivered 46,974 doses of chemotherapy. Of these 19,979 were delivered at the Clatterbridge Cancer Centre, 26,247 were delivered in the outreach sites and 748 of these doses were delivered in patient's homes.

During our visit, we spoke with ten patients and 18 members of staff. We looked at a range of policies, procedures and other documents relating to the running of the service. We reviewed 25 sets of care records and 14 medication records.

Summary of findings

We rated the chemotherapy service outstanding because:

- The service had a clear focus on safety and patient centred care. Safety was a high priority throughout the service and there was routine measurement and monitoring of safety and performance within the service. Risks were appropriately and identified.
- We found that the care delivered to patients was evidence-based and in line with key documents such as National Institute of Health and Care Excellence guidance. There was routine monitoring of patient outcomes of care and treatment, and patient feedback was actively sought on a regular basis.
- The training for staff involved with the delivery of chemotherapy was appropriate to their role and provided on a regular basis. Staff appraisals were completed. All teams within the service worked effectively and engaged with other professionals to ensure patients received the required level of care and support. Staff spoke very positively about the support they were given by leaders and management. Managers within the service lead by example and staff told us they were inspirational.
- Staff treated patients as partners in their care and treatment and empowered them to make choices about their treatment plan and direction. Staff were passionate and committed to providing outstanding

care. Staff were observed providing care to patients with kindness, compassion and dignity. Staff at all levels routinely went the extra mile to provide outstanding care to patients.

- Individual needs were identified and responded to appropriately. The service also provided an innovative and comprehensive chemotherapy program in patients own homes and were considering offering this service in workplaces. Psychological support, counselling and complementary services were all provided free of charge for patients and their relatives.
- The service had introduced an innovative 'rapid chair' initiative in response to issues with patients experiencing delays. This meant that patients who were receiving short periods of chemotherapy did not experience delays. This service was introduced in direct response to patient feedback.
- The service had a comprehensive strategy and business plan, which took into account sustainability for the future. The service was responsive to patients' needs and fully took into account the needs of the population they served. The service had adapted to meet the needs of the patients using their services and was actively engaging with the public regularly to ensure that they provided services that met their needs. Patients could access treatment and care in a timely way. All patients we spoke with told us that they had experienced no delays in accessing chemotherapy and eight out twelve patients told us they were surprised at how quickly their treatment had been commenced.
- All patients we spoke with told us that the care they received from the service exceeded their expectation.

Are chemotherapy services safe?

We rated the service as good for safe domain because:

Good

- Safety was a high priority and there was routine measurement and monitoring of safety and performance within the service.
- We saw evidence in patient records that risks were identified on an individual patient basis and appropriate action was taken by staff in response to these risks. This included specific risks relating to cytotoxic (chemotherapy) medications. Medical response was timely when required.
- Nurse staffing levels were adequate for the delivery of the service and based on an acuity tool. Staff sickness and turnover rates were as expected.
- Staff understood the importance of reporting and learning from incidents and learning was disseminated effectively.
- Medicines were managed well and in line with national guidance and legislation. The service effectively managed cleanliness, infection control and hygiene. The clinical areas we inspected were visibly clean and well maintained.
- There were clear and specific protocols and processes for staff to follow in relation to the storage, management and disposal of chemotherapy medications.
- Staff told us that they felt well-staffed and they felt that they had enough time to care for patients.
- The training for staff was appropriate and provided on a regular basis through links with local universities and education establishments.
- Safeguarding was well managed in the service, training was up to date and staff felt confident to report issues when raised.

However:

• Mandatory training was below the trusts target in some subjects including Medicines Management which was lower than the trusts target of 95% with only 81% of required staff completing level 1 training. This had been recognised by the service lead and the service had a comprehensive action plan in place to address areas of low uptake levels.

Incidents

- Staff were aware of the reporting systems for incidents and staff had access to the trust-wide paper basedelectronic reporting system.
- Staff showed us how they would open the incident system on the computers in their offices. There had been no incidents reported within the service that met the serious incident criteria.
- Learning from incidents was shared with staff at regular team meetings and debrief sessions.
- There was a daily meeting in the morning on the Delamere Unit. All staff, including staff working in the community and at satellite clinics were required to attend this briefing. Important messages such as aspects of learning from incidents were shared at this briefing. This enabled managers to pass on learning immediately and ensured all staff received the same information.
- We also saw evidence of incidents being discussed at team meetings and in the daily briefings on the Delamere Unit.
- Staff told us that they felt comfortable raising incidents and confirmed that they always received timely and appropriate feedback when they submitted an incident form or raised a concern.

Safeguarding

- Policies and procedures for safeguarding vulnerable adults and children were accessible to staff electronically.
- Staff received mandatory training in safeguarding children and vulnerable adults that included aspects of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. The service had a high uptake of level 1 safeguarding adults at 90%. The uptake rate for level 2 safeguarding training was lower than this at 37.5% as only three staff out of eight who required this training had undertaken it.
- The uptake rates for safeguarding children level 1 were high at 91%, nine out of 10 staff members who required this training had undertaken the training. The uptake rate for level 2 safeguarding training was lower at 75%. The service had a comprehensive action plan in place to

address areas of low uptake levels. This action plan had measurable actions and outcomes and was being monitored by the unit manager and the service manager.

- We found that staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and were aware of the process for reporting safeguarding concerns and allegations of abuse within the trust.
- Staff confirmed safeguarding was always raised at key staff meetings.
- Staff told us that they felt confident dealing with matters of a safeguarding nature and were able to give us recent examples of cases they had dealt with.
- Staff told us that they received meaningful feedback if they raised a safeguarding concern.

Medicines

- We found that the trust had an up to date policy on the management of medications, including individualised standard operating procedures for chemotherapy treatments. This policy reflected current guidance and was easy to understand and accessible to staff electronically.
- The staff we spoke to were knowledgeable about the different medication therapies they were administering.
- We found that the storage of chemotherapy products was in line with national guidance. It is important that chemotherapy medications are stored at the correct temperature as incorrect storage can affect how well the medication works.
- We observed staff preparing and administering chemotherapy medications in the Delamere unit, a satellite clinic and in a patient's home. In all settings, we observed that staff were undertaking the appropriate checks prior to administering the medication and monitoring patients in line with the individual protocols for each medication.
- We reviewed 20 medication records across team areas and we noted that these prescriptions were up to date, clear and unambiguous.

- The process for the destruction of controlled drugs was clearly set out in the trust's policy on the management of controlled drugs. Staff followed this process and ensured that these medications were destroyed following the death of patients in their own home.
- Medications were stored in suitable cupboards, cabinets and fridges. There was a designated locked room in both the Delamere unit and in satellite clinics. When medication was being transported for administration in patient's homes, it was stored in lockable 'cold' boxes in designated vehicles. These boxes meant that the medication remained at the correct temperature to be administered.
- Nursing staff on the unit and working in the community undertook training in medicines management. This training was delivered in two courses. The first was medicines management awareness training which was classed as level 1 training, staff were required to complete this training on a two yearly basis. Staff were also required to undertake a level 2 training course in this subject on an annual basis.
- The uptake rate for the level 1 medicines management training was low at 81%; this meant that only two out of the six staff who were required to undertake this training had completed the training at the time of the inspection. The uptake rate for the level 2 training was 78%; however, this was also below the trusts standard of 95%. The service had a comprehensive action plan in place to address areas of low uptake levels. This action plan had measurable actions and outcomes and was being monitored by the unit manager and the service manager.

Environment and equipment

- All clinic settings we visited were easily accessible and clearly signposted. There was also lift access where clinics were not on the ground floor.
- There was a large seating/waiting area for patient using the Delamere Unit; clinical rooms and bays were visibly clean and tidy, bright and organised. There were also private rooms that were used for patient consultations.
- Patients we spoke with told us that they felt that the environment and the facilities were very good.

- Portable equipment was portable appliance tested (PAT) and dated. The equipment we checked had been tested within the required time frame.
- Staff carried out regular checks on key pieces of equipment. Emergency resuscitation equipment was readily available and records indicated that it had been checked daily, with a more detailed check carried out weekly, as per the hospital policy.
- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- The fridges used on the Delamere unit had temperature monitors that were monitored remotely by the pharmacy team to ensure the temperature did not fall outside of suitable range. Alarms were activated automatically if temperatures in the fridges rose outside of these ranges.
- The room temperature of the storage room was also monitored regularly.
- There were clear and robust processes for the maintenance and checking of equipment provided to patients in their own home. Staff were able to describe the processes and how they followed them.
- We observed the storage equipment at the Delamere unit and found that this storage was appropriate and well maintained.

Quality of records

- The service and trust used paper based patient records to record the care patients received. Some records such as test results, referrals and x-rays were available electronically using secure log ins. We reviewed 25 patients' care records and found them to be legible and easy to follow. We found that patients' nursing and medical records were kept up to date and fully completed in all cases.
- The unit and service manager on a regular basis audited records during reviews and any issues were highlighted to staff immediately.
- Records were stored in records trolleys and in secure consultation rooms. These trolleys were found to be unlocked but were not easily accessible to members of the public.

Cleanliness, infection control and hygiene

- The service effectively managed cleanliness, infection control and hygiene. The clinical areas we inspected were visibly clean and well maintained.
- The service regularly undertook infection prevention control and controlprevention audits and we reviewed three months data in relation to these audits. All showed good compliance with hand hygiene and basic infection prevention measures.
- Staff were aware of current infection prevention and control guidelines, and were able to give us examples of how they would apply these principles.
- Cleaning schedules were in place, with allocated responsibilities for cleaning the environment and decontaminating equipment. In all cases, we found that these had been completed within their required timescale.
- There was adequate access to hand washing sinks and hand gels in all areas.
- Staff were observed using personal protective equipment, such as gloves and aprons and changing this equipment between patient contacts. We saw staff washing their hands using the appropriate techniques and all staff followed the 'bare below the elbow' guidance.
- Personal protective equipment (gloves and aprons) and hand cleansing products were available to all staff undertaking patient care.
- We observed that all staff when dealing with patient intravenous lines used appropriate aseptic techniques. It is important that additional measures are taken to protect patients from infection when dealing with these lines as infections acquired in these lines can be severe.

Mandatory training

• Uptake rates for mandatory training varied across different subjects within the service with some high uptake rates and some subject areas with very low uptake. This had been recognised by the service lead and the service had a comprehensive action plan in place to address areas of low uptake levels. A designated sister was charged with monitoring and implementing this action plan. This action plan had measurable actions and outcomes and was being monitored by the unit manager and by the service manager.

- Staff working within the service received mandatory training on a rolling annual and bi annual basis and the trust wide standard for uptake of this training was 95%.Subjects on this programme included infection control and prevention, health and safety and fire safety.
- Mandatory training on consent processes was provided for staff and records showed that only 33% who required this training had completed the training. There was a higher uptake rate for equality and diversity training at 91% of staff having undertaken this training with only one staff member having not undertaken the training.
- Fire safety was also a mandatory training subject and records showed that 100% of staff who required this training had undertaken the training. The uptake rate for infection control and prevention was also higher than the trusts standard at 100% having undertaken this training.
- Training in health and safety was provided on an annual basis and 83% of staff who were required to undertake this training had completed the course at the time of the inspection. Staff also received mandatory training on moving and handling patients, records showed that 91% of staff in service had completed this training at the time of the inspection.
- There were a number of training subjects which had recently been added to the mandatory training programme and as a result levels for these subjects was lower than the trusts standard. One such example was training for all staff in relation to identifying radicalisation. The service had clear and achievable schedules to train all staff within a short timescale and records showed that they were on track to train all staff in this subject within a three-month period.

Assessing and responding to patient risk

• Processes were in place to manage risks to patients such as deterioration or reaction to medications. These included detailed assessments within the unit and clinics prior to commencement of each treatment. This detailed assessment included staff assessing specific

risks associated with systemic anti-cancer therapies. We observed and example of this where an experienced nurse checked a patient blood tests relating to their kidney function, as the medication they were receiving could affect their kidney function. They discussed the results with a senior nurse practitioner before allowing the patient to commence treatment.

- Each patient was scored for potential toxicity to the therapy they were receiving and checked for potential acute kidney injuries. In all records we reviewed, we found that this scoring had been completed fully.
- All patients received a comprehensive assessment when they arrived at the unit or clinic sites. This included a full set of observations, a series of questions tailored around their treatment and a review of relevant blood tests.
- In relation to home treatments, which were available, these were assessed thoroughly as appropriate for home delivery to minimise the risks to patients receiving care away from the main hospital.
- We saw evidence in patient records that risks were identified on an individual patient basis and appropriate action was taken by staff in response to these risks and risk assessments were completed for example for falls where relevant for patients. In all cases, we found that the appropriate risk assessments for patients were fully completed on and acted on where required.
- Where there were significant risks identified, we found that staff responded appropriately such as involving other multi-disciplinary teams to seek advice and ensure a joined up multi-disciplinary approach was taken to mitigate risk.
- An early warning score (EWS) system was in use. The EWS system was used to monitor a patient's vital signs and identify patients at risk of deterioration and prompt staff to take appropriate action in response to any deterioration. Staff carried out monitoring in response to patients' individual needs to identify any changes in their condition quickly.
- We observed staff treating a patient when they deteriorated on the unit. Staff identified the deterioration quickly and took appropriate action immediately. Within a 7 minute period the patient had

been allocated a bed, been reviewed by a senior doctor, nurse practitioner and had commenced treatment to treat the cause of their deterioration, after which they made a significant improvement.

Nursing staffing

- Staff worked on a one or two nurses to a bay ratio. This meant that one nurse would be responsible for looking after a maximum of four patients. Staff told us that they felt well staffed and that they had enough time to care for patients.
- The service used an adapted nationally recognised acuity tool to determine the numbers and skills of staff they required within the service.
- In April 2016 the chemotherapy services directoratedivision had 2.5 whole time equivalent nursing vacancies. The ward manager and service manager showed us evidence that these vacancies were being actively recruited into and they hoped to have them filled by September 2016.
- The ward manager and service manager monitored sickness rates. Data provided by the trusts showed that between April 2015 and April 2016 the sickness rate for nursing staff in chemotherapy services was 4.4%. This was about the same as the national average sickness rate for NHS staff.
- The turnover rate for nursing staff in chemotherapy services was 16%, which was slightly above the trusts standard of 14%.

Medical staffing

- The chemotherapy services were predominantly nurse led in their delivery. However, medical staff carried out consultations regarding the commencement of treatment and changing treatments.
- Medical staff were readily available for nursing staff within the service to seek advice and patient reviews.
- Staff told us that medical staff were easy to access and always attended the unit when required.
- Medical staff were accessible either by mobile telephone or a bleep system.
- We observed a number of clinicians responding to calls from nursing staff on the unit in a prompt manner.

• The percentage of consultants working at the trust was 54%, which was higher than the national average of 34%. The percentage of middle grade doctors were about the same as the national average of 6%. The percentage of registrars (senior doctors) was 34%, which was lower than the national average of 39%. The percentage of junior doctors working in the trust was 4%, which was lower than the national average of 22%.

Major incident awareness and training

- The hospital was not a part of the local major incident plans. Despite this, The trust was a member of the Merseyside Local Health Resilience Partnership (LHRP) and there were clear major incident plans available on the trust intranet site.
- Staff were aware of how to find the trust policy on managing major incidents.

Are chemotherapy services effective?

We rated the service as good in relation to the effective domain because:

Good

- Staff provided care that was based on national best practice guidance and the latest clinical guidelines. The service undertook routine internal audit to measure compliance with these guidelines. In the trust wide 2015 audit on consent procedures they demonstrated that in 100% of cases reviewed the benefits, risks and options were discussed and documented on the consent form.
- The staff we spoke with were competent and passionate about their roles, The service had a comprehensive portfolio of competencies and standards for all staff. There was a senior specialist oncology and chemotherapy nurse based on the unit every day who also facilitated practice development for staff on the unit. Staff within the service worked closely and effectively together to facilitate high quality patient care. They were encouraged to share case studies to promote learning by the whole team. The specialist nurse also worked with staff on a one to one basis if needed to help them develop and strengthen key skills.

- One case regarding undiagnosed diabetes in patients living with cancer and how steroid use could affect patients' blood sugars had resulted in staff working together to develop an initiative to identify diabetes on pre admission.
- The service scored in the top 20% of all services who participated in the peer review across England in relation to the provision of information and assessment of patient's psychological needs. Patient assessments were holistic and took account of all patient needs. t was holistic; p
- The trust and service were also leading and developing a living with and beyond cancer program. This program aimed to improve outcomes for patients living with a beyond cancer and one of its components was the development of a set of patient related outcomes (PROM's). These PROM's were designed to assess the outcomes of patients living with cancer and measured at specific issues such as fatigue and psychological support. At the time of the inspection these PROM's had not been implemented for a sufficient time to allow meaningful results.
- The trust were part of the development of the West Cheshire Care Record program where key information about patients was stored securely and could be accessed from multiple sites. This meant that staff could view the patients latest test results and emergency attendances from multiple locations.
- The service participated in the National Chemotherapy Multi-Disciplinary Team (MDT) Peer Review (2014). Results from this peer review showed that the service was compliant with 35 out of 36 standards and scored 97.6% overall.
- The service scored 100% overall compliance with the 19 standards for intrathecal chemotherapy in the National Chemotherapy MDT Peer Review (2014).
- Chemotherapy services took part in research and routinely offered clinical trials to patients when they were assessed as being suitable.
- Staff were aware of the Mental Capacity Act (2005) and how they would apply this in practice.

Evidence based care and treatment

- Patients accessing the chemotherapy services received care and treatment in line with evidence based practice and national guidelines. Clinical audits included monitoring compliance with National Institute for Health and Care Excellence (NICE).
- A range of evidence based clinical pathways and operating procedures for different treatments were available and were in place for patients who required them. These included medication specific pathways for different chemotherapy treatments and pathways for other clinical issues such as sepsis. These pathways included clear prompts, checks and treatment steps for staff to follow. The pathways and treatment guidelines were regularly reviewed on a trust wide and service basis and reflected current guidance from with National Institute for Health and Care Excellence (NICE) and other leading national organisations.
- Policies and procedures reflected current national guidelines and were easily accessible via the trust's intranet site.
- The service also had a comprehensive internal audit plan. This plan included audits on infection control standards, medicines management and the compliance of staff with pre-treatment assessment guidelines. At the time of the inspection, the service was up to date with this audit plan and each audit had an associated action plan for any areas of non-compliance. We found that these action plans were updated regularly with measureable and realistic actions and updates.

Pain relief

- There was evidence in patients records that pain relief had been prescribed appropriately and was administered when they required.
- All patients we spoke with spoke positively about the way in which their pain was managed.
- There was evidence within records of patients receiving chemotherapy that pain was being assessed regularly.

Nutrition and hydration

- Staff told us that they were able to access specialist dietetics advice and support easily when required.
- There was adequate access to food and drink in the Delamere unit and in all satellite clinics, we visited.

Patients also had the option of purchasing their own food from tea bars and shops located near to the clinics. Patients did not highlight any concerns about the food and drink provided.

- In all records we reviewed, there was evidence that nutrition and hydration had been considered when appropriate and a malnutrition universal screening tool (MUST) risk assessment tool completed where appropriate.
- The Maggie's Merseyside charity based at the centre were also able to offer practical advice on nutrition and hydration during treatment to patients. Two patients we spoke with told us that they found the advice and support they received from this service had helped them with their nutrition while undergoing chemotherapy.

Patient outcomes

- Chemotherapy services participated in national and internal audits to monitor patient outcomes. Outcomes for patients receiving treatment in the service were mostly the same or better than the England average.
- The service participated in the national Systemic Anti-Cancer Therapy Data Completeness report in 2015. This report shows how complete the data around patients care is and includes fields such as patient details, treatment intent and treatment plan. The chemotherapy services performed about the same or better than the England average for 30 out of 45 data fields and worse than the England average for 11 out of 41 data fields. In some fields which showed the service as below the England average, this was by a narrow margin. We saw evidence during the inspection that the service had taken measures to address shortfalls in these areas. One example was that all patients were measured for height and weight on arrival to the Delamere unit, as this was an area highlighted as being below the England average in this report.
- The service was actively accessing the national cancer drugs fund for patients. The service monitored the number of patients who received medications from this fund and documented this data into the Blueteq system so they could track and monitor patients accessing this fund. Reports from this system showed that since 2014 the service had performed over the 90% standard for accuracy when submitting data to the Blueteq system.

- The service participated in the National Chemotherapy Multi-Disciplinary Team (MDT) Peer Review (2014). Results from this peer review showed that the service was compliant with 35 out of 36 standards and scored 97.6% overall. The area for concern highlighted related to the workload of nurses in the service due to the progression of nurses into specialist roles. We found that this was being actively addressed through on going recruitment into vacant posts in the service. The service had a plan to address these recruitment issues and the number of vacancies had reduced in the months prior to the inspection.
- The service scored in the top 20% of all services who participated in the peer review across England in relation to the provision of information and assessment of patient's psychological needs.
- The service scored 100% overall compliance with the 19 standards for intrathecal chemotherapy in the National Chemotherapy MDT Peer Review (2014).
- The services systemic anti-cancer therapy program was reviewed and audited in June 2015 to assess its efficacy and effect on patients. This was done through a survey of patients and reviews of patient records. The survey included all patients who were receiving therapy at home, 100% of patients returned their surveys. Results from this survey showed that patients were very happy with the service they received at home with 100% of patients saying they were satisfied with the service. A number of reasons for this were given including reduced stress and anxiety and improved emotional state.
- The trust and service were also leading and developing a living with and beyond cancer program. This program linked three regional work streams together; the development of a charter, the development of a cancer strategy and the living with and beyond cancer program. This program aimed to improve outcomes for patients living with a beyond cancer and one of its components was the development of a set of patient related outcomes (PROM's). These PROM's were designed to assess the outcomes of patients living with cancer and measured at specific issues such as fatigue and psychological support. At the time of the inspection these PROM's had not been implemented for a sufficient time to allow meaningful results.

- Appraisal rates were high within the service at 88% for nursing staff for the 2015/2016 period. This equated to 28 out of 32 staff working on the unit. Managers told us that of the four staff who had not received their appraisal two were not in work to allow an appraisal to take place. The unit manager had comprehensive plans in place to ensure all appraisals were completed in this financial year. They had also ensured that staff who did not receive an appraisal last year were listed for an appraisal first in the next financial year.
- Staff told us that they were actively encouraged to undertake training additional to their mandatory requirements and were supported to improve their knowledge if they identified areas of improvement.
- All staff involved in the delivery of chemotherapy were required to undertake specialist additional training. The service worked closely with a local university to provide this training for staff involved with the delivery of chemotherapy.
- The service had a comprehensive portfolio of competencies and standards for all staff to complete when they started working within the service. This portfolio included a set of practical and theoretical competencies for staff to complete and required countersigning by a senior staff member. These competencies covered key aspects of the role of a nurse working with chemotherapy medications such as medication safety and the effects of chemotherapy.
- There was a senior specialist oncology and chemotherapy nurse based on the unit every day. This nurse also facilitated practice development for staff on the unit. This included provision of short courses and training subjects for all staff including those working in satellite clinics on pertinent subjects. Staff told us they felt able to approach this nurse and request training in any subject.
- Staff were also encouraged to present subjects or cases that they felt other staff could learn from at regular meetings. One example of this was a nurse who presented a session regarding undiagnosed diabetes in patients living with cancer and awareness of how steroid use could affect patients' blood sugars. As a result of this staff worked together to develop an

Competent staff

initiative to identify diabetes on pre admission. At the time of the inspection, the staff in the pre assessment area were trialling urine analysis on pre assessment to look for signs of undiagnosed diabetes.

- The specialist nurse also worked with staff on a one to one basis if needed to help them develop and strengthen key skills.
- Although the service had a low rate of agency nursing usage. All agency nursing staff underwent local inductions and were required to complete an induction checklist when they attended the area.
- There was a culture of debrief, supervision and learning with daily meetings and supervision provided by senior staff.
- The manager of the service monitored the professional registration of all nurses working in the service on a regular basis. The service had also developed support mechanisms for nurses to complete their three yearly revalidation process.
- The staff we spoke with were knowledgeable about the therapies they were providing and appeared competent in their roles, undertaking all the relevant duties and checks required.

Multi-disciplinary working and coordinated care pathways

- There was a multi-disciplinary team approach to the planning and delivery of all aspects of chemotherapy.
- We observed excellent multi-disciplinary team working during our inspection with advice being sought from multiple disciplines and support being provided to facilitate excellent patient care.
- We saw extensive evidence of multi-disciplinary team working to facilitate the best possible care for patients and their families. One example of this was related to a patient who was not attending for chemotherapy appointments. We observed in this patient's record that the service had worked closely with the patients GP; oncologist and transport services to ensure the patient could access their therapy. Measures taken included arranging for the patient to receive therapy at a satellite clinic close to their home and working with a local charity to offer the patient advice on benefits they may be entitled to.

• There were regular multi-disciplinary team meetings relating to chemotherapy patients and also condition specific meetings where the input of additional clinicians would be sought. For example a surgeon in relation to breast cancer patients.

Seven-day services

- At the time of our inspection outpatient, clinics at the Delamere Unit and satellite clinics operated from Monday to Friday between 8.30am and 6.30pm. The home treatment service also operated during these hours.
- Diagnostic services were available during all hours of opening and additionally they were available 24 hours a day, seven days a week.
- Pharmacy services were available during all hours of opening. There was also support available out of hours via an on call rota if patients treatments over ran.
- Patients were able to access support and advice from the inpatient wards by telephone outside of the operating hours of the Delamere Unit. All patients we spoke with told us they felt supported throughout all days of the week.

Access to information

- Staff accessed patient details through paper patient records or from the electronic patient system.
- Staff told us that they found it easy to access information about patient's previous admissions and attendances, including admissions and attendances at other trusts.
- The trust were part of the development of the West Cheshire Care Record program. This program meant that key information about patients was stored securely and could be accessed from multiple site through secure log ins. This meant that staff could view the patients latest test results and emergency attendances from multiple locations.
- Medical staff produced regular clinical updates from the electronic patient system and sent them to the patient's general practitioner (GP) in a timely way. This meant that the patient's GP would be aware of their treatment and could arrange any follow up appointments they might need. Patients were also offered the option of having these letters copied to them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to tell us clearly about how they sought informed verbal and written consent before providing care or treatment.
- We observed that staff sought appropriate consent from patients prior to undertaking any treatment or procedures.
- All patient records we looked at indicated that staff had sought and obtained verbal or written consent before treatment was delivered.
- The service participated in the trust wide 2015 audit on consent procedures and performed well in most areas. The results from this audit showed that in 100% of cases reviewed the benefits, risks and options were discussed and documented on the consent form. In 98% of cases, the form had been signed by the patient and the consultant providing the treatment. The section relating to whether patients had been provided with relevant materials about their procedure was lower than expected at 82%. However, this was an increase in compliance compared to the 2014 audit.
- Staff were aware of the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Registered nurses and health care assistants did not routinely receive training on the application and responsibilities of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. However, aspects of these subjects were included in the mandatory safeguarding training for all staff.
- A trust-wide safeguarding team provided support and guidance for staff in relation to any issues regarding mental capacity assessments and deprivation of liberties safeguards. They were easily accessible and we observed them interacting with staff on the Delamere unit when required.

Are chemotherapy services caring?

Outstanding

We rated the service as outstanding in relation to the caring domain because:

- The culture within the service was strongly patient centred and motivated staff to provide a high standard of compassionate and dignified care. Staff were passionate and committed to providing compassionate, holistic care to patients and their relatives.
- Patients were truly valued and were treated as partners in their care and treatment. Staff encouraged patients and their relatives to be partners in their care and ensured that they were consulted on all decisions relating to their treatment.
- Staff had strong relationships with patients and their relatives, involved them in their care and these relationships were highly valued by staff.
- Staff showed determination to overcome obstacles and challenges to delivering the holistic care patients needed. We saw a number of examples of staff going the extra mile to provide person centred, compassionate care and ensure that patients and their relatives received the emotional and practical support they need.
- A patient receiving treatment on the Delamere Unit told us that "Cancer is the loneliest place to be in the world, when you're standing in a storm alone and wondering what to do and its dark and then suddenly you've got all these friendly faces looking at you and offering you a hand to get through. That's what the staff here do, they pull you through or even carry you through that storm which is the darkest time of your life and they lighten it up for you."
- Staff considered the totality of the needs of patients and their loved ones and the feedback we received from patients was unanimously positive
- We found that there were multiple examples of staff going the extra mile to provide outstanding patient care. These included working outside of their hours, visiting patients in a hospice when they had no living relatives and fundraising in remembrance of patients.
- The service also provided a number of caring interventions to help patients feel at ease including a pet therapy dog, alternative therapy and relaxation techniques.

Compassionate care

• Staff respected patients and their relatives and valued them as individuals.

Summary

- The care provided in all areas of the service was person centred and the culture within the team reflected this.
 All interactions that we witnessed were patient centred and conducted with dignity and respect.
- We observed interactions between patients and staff. Staff were courteous and caring towards patients at all times. Staff displayed a high level of compassion and understanding when communicating and supporting patients.
- We observed handover and spent time in a number of clinics and offices listening and observing staff talking to patients in person and on the telephone. Staff spoke respectfully and compassionately to patients and about patients at all times.
- The culture within the service was one of 'family' and numerous patients told us they felt part of the Clatterbridge family.
- All relatives and patients told us that staff were always kind, caring and compassionate. All patients told us that staff went beyond their duty to provide compassionate care.
- All staff displayed attitudes that were passionate about providing compassionate care.
- We were also told of times where staff in the community team would make food for patients if they were unable and also ran errands for them when they had no relatives who could do this.

Understanding and involvement of patients and those close to them

- Staff displayed a person centred approach and went beyond their duty to provide care to patients, which met their needs. Staff valued patients and their relatives as partners in their care.
- All patients told us that they had been involved with decisions about their care and had been actively involved in their treatment and care plans.
- The staff within the service worked closely together to ensure that all the patients' needs were identified and met in a holistic way. One example of this was considering patients family and home circumstances in the case of a mother. The team ensured that this patient could receive their chemotherapy at home so they could still collect their children from school. In another case, a

patient told us that the staff made their journey easier by looking at them holistically and considering that, they were working full time and delivered their therapy around their working hours.

- Staff worked very hard to ensure that patient's relatives and loved ones were supported through the patient's journey. One example of this was a patient with a teenage child who was very nervous and scared for their parent to attend chemotherapy. The nurse in charge of the satellite clinic where the patient would be attending arranged for the child to come into the clinic. When they came in, they were shown around the clinic and taken through what would happen to their parent. They were also offered the opportunity to speak with the senior nurses and an oncologist about chemotherapy and ask any questions they may have had. The patient and their child told us that this alleviated their fears and they were then comfortable to attend chemotherapy sessions with their parent to support them.
- Staff showed determination to overcome obstacles and challenges to delivering the holistic care patients needed. One example of this was the community team working closely with GP's and other services to ensure patients received chemotherapy if they required and wished for it. In one case, the team had worked above and beyond their hours and scope to ensure that a patient with severe anxiety could receive chemotherapy safely at home. This allowed the patient to be in the most comfortable and supportive environment for them.
- Within the Delamere, unit and some satellite clinics there was an end of treatment bell. This bell would be rung by a patient when they completed their treatment. All the staff and patients would gather around the bell and give a round of applause to the patient. We observed this occurring once during our inspection and the patient was very emotional and told us that to them it signified a closing point in their treatment and something for them to work towards.

Emotional support

- We observed patients and their relatives being offered and provided with emotional support and we saw evidence of this in patient's records.
- The staff worked hard with partnership agencies to support patients and their relatives. An example of this

was the close working relationship with the Maggie's Merseyside charity centre based in the Clatterbridge Cancer Centre. This centre offered counselling and emotional support for patients and their relatives.

- A patient told us that they had received exceptional support from the staff on the Delamere Unit. This patient told us that the staff were so caring and treated them with dignity and respect. They also told us that they felt able to discuss all their fears and worries with the staff during chemotherapy so that when they left they could 'leave cancer at the door'. They told us that this support from the staff helped them return to being a mother, wife and person when they left and not just a cancer diagnosis.
- If patients who had been attending the unit or clinics passed away, staff made efforts to ensure that a representative from the unit attended the funeral. We also heard of an example where nurses from the service had attended a hospice to visit a patient in the last days of life and taken them their favourite food, as they had no living relatives.
- All patients and relatives we spoke with were very positive about the emotional support they received from all professionals.
- Another example of staff adapting their emotional support to meet a patients needs was when a particularly anxious patient attended. The specialist nurse had identified their anxiety and as a result ensured that an additional member of nursing staff was present during their treatments to provide one to one support and distraction techniques if needed.
- Relaxation therapy techniques were also taught and offered by the nursing staff and Maggie's Merseyside. This included hand and feet massages to help calm and relax patients while they were receiving chemotherapy.
- The service was also visited on a daily basis by the pet therapy dog and her handler. Patients and their relatives told us that this helped relax and calm them when they were receiving therapy. One patient told us that they had unfortunately had to give up their pet dog when they became ill. They told us that they were very grateful to be able to see the pet therapy dog as she offered them comfort and support.

• Staff frequently took part in charity projects for the Clatterbridge Cancer charity. Patients told us that this made them feel supported and that staff really cared about them. One patient relative told us that their relative had become too unwell to complete a charity challenge. They told us that because of this a member of staff took over the challenge and completed it in their honour.

Are chemotherapy services responsive?

Outstanding

53

We rated the chemotherapy service as Outstanding in relation to the responsive domain because:

- The needs of the local population were truly taken into account when planning the delivery of services and the service routinely sought patient feedback when planning or changing services. An example of this was the growth in the number of satellite and outreach clinics within local communities was as a result of the service reviewing where the largest group of patients accessing their services lived.
- They also worked closely with local acute hospitals with a number of acute specialist nurses employed by Clatterbridge Cancer Centre NHS foundation trust worked in the acute hospital and reviewed and assessed any patients in receipt of chemotherapy at Clatterbridge who were attending the emergency department or admission units. They were able to offer specialist advice to the staff on the unit and also worked with clinicians to facilitate the patients discharge or transfer.
- The vast majority of chemotherapy was prescribed in advance for patients and also prepared beforehand. The service licensed its production unit with the MHRA & validated its cold-chain procedures to ensure that patients did not have to wait for their chemotherapy to be prepared and the services logistics allowed patients to be treated across the whole of their network and at home.
- Individual needs were also identified and responded to appropriately. The service also provided an innovative and comprehensive chemotherapy program in patients

own homes and were considering offering this service in workplaces. Psychological support, counselling and complementary services were all provided free of charge for patients and their relatives.

- The service was meeting the standards relating to providing care in a timely way. Between April 2015 and March 2016, an average of 91% of patients received their first treatment within 62 days of receipt of referral. For the same period, 96% of patients received their first treatment following a decision about treatment, within 31 days. Staff had taken measures to address any areas where they were not meeting these standards and had set internal unit wait targets which were actively improving patients' waits for treatment.
- The service had introduced an innovative 'rapid chair' initiative in response to issues with patients experiencing delays. This meant that patients who were receiving short periods of chemotherapy did not experience delays. This service was introduced in direct response to patient feedback.
- Consideration was given to patients living with a disability and their treatment could be tailored to meet their needs including where the treatment was delivered. Reasonable adjustments were also made for patients including hearing loops and translation.
- Patients reported that they received a good service.
- Patients could access advice and support 24 hours a day.
- Complaints were well managed, within agreed timescales and evidence of action taken as a result of them was evident.

Planning and delivering services which meet people's needs

- The service was adapted and tailored to meet the needs of the local population. We found that patient's needs were central to the planning and delivery of local services.
- An example of this was the growth in the number of satellite and outreach clinics within local communities. This growth was as result of the service reviewing where the largest group of patients accessing their services lived.

- The service provided a comprehensive and innovative chemotherapy at home program. This program allowed patients to be treated in their own home for a variety of reasons. The service was very flexible and accommodated a wide range of patient needs including fear of hospitals, personal choice and clinical condition. The service was not limited to delivering simple chemotherapy medications but adapted and responded to provide more extensive treatments in patient's homes. This service was also delivered by senior staff who were employed by the trust. This ensured that they were trained and inducted to the trusts standards and had access to the trusts development programs. Data about the service was monitored closely and the service was regularly developed and adapted to respond to patient need and requests. An example of this was that the service was planning to extend this service to patient's workplaces after requests from patients.
- Psychological support, counselling and complementary services were all provided free of charge for patients and their relatives.
- We were told by senior staff that they routinely sought patient feedback when planning or changing services. This was completed through local consultation with service user groups and was supported by third party organisations including charities.
- The service also worked closely with local acute hospitals to identify and assist when patients accessed other services. We observed this in action in a local hospital. The hospital had a number of acute specialist nurses employed by Clatterbridge Cancer Centre NHS foundation trust working in the acute hospital. These nurses would review and assess any patients in receipt of chemotherapy at Clatterbridge who were attending the emergency department or admission units. We observed this nurse assessing two patients on the medical admissions unit. They were able to offer specialist advice to the staff on the unit and also worked with clinicians to facilitate the patients discharge or transfer. This initiative ensured that the service had an up to date view of all patients' attendances and admissions at other hospitals in the area.

Access and flow

• The Department of Health sets outpatient departments to achieve a number of standards to meet in relation to

cancer services. These standards ensure patients do not wait too long for appointments to treat and diagnose cancer. The first standard is that 85% (or 90% if referred by national screening program) of patients referred to hospital with suspected cancer should receive their first definitive treatment within 62 days of being referred and that 96% of patients should have their first treatment following the decision about their treatment within 31 days of referral. Chemotherapy services were regularly meeting these standards and had met them in relation to both standards for the 12-month period prior to the inspection.

- Between April 2015 and March 2016, an average of 91% of patients received their first treatment within 62 days of receipt of referral. For the same period, 96% of patients received their first treatment following a decision about treatment, within 31 days.
- The trust and service also had local standards in relation to waiting and treatment times. One of these was that 88% of patients should receive a pre assessment for Chemotherapy within seven days of their first cycle of treatment. The service consistently scored above this target for eleven out of twelve months. With the one month where they did not meet this standard being only slightly lower than the target at 86%.
- The Delamere unit had a standard to see a minimum of 80% of patients within 30 minutes of arrival. They did not meet this target for five out of twelve months between April 2015 and March 2016. The manager for the unit was aware of this and as a result had asked patients and staff, where the delays were occurring. They found that the delays related to the longer treatments lasting a number of hours. As a result, the service and unit manager implemented a number of rapid chairs. These chairs were used to administer chemotherapy to patients requiring shorter treatments. This meant that patient requiring shorter treatment would not have to wait for the longer treatments to finish and therefore could be seen more quickly. At the time of the inspection, there was evidence that this had improved waiting times as the service had met this standard for the seven months prior to the inspection. This data also showed that the percentage of patients

being seen on time was improving over these months. The service had also received interest from other providers who were looking to introduce a similar system.

• The vast majority of chemotherapy was prescribed in advance for patients and also prepared beforehand. The service licensed its production unit with the MHRA & validated its cold-chain procedures to ensure that patients did not have to wait for their chemotherapy to be prepared and the services logistics allowed patients to be treated across the whole of their network and at home.

Meeting individual needs

- The service treated patients living with dementia on occasions. Staff had access to a specialist nurse who was the trust lead for dementia and also the safeguarding specialist team who were able to offer practical support and advice. The trust had a strategy in place to address and implement the recommendations from the national dementia strategy. One of the objectives included improving the experience for patients accessing services who were living with dementia. The unit manager was working with staff to develop ways to improve the journey for patients living with dementia.
- The nursing staff within the service gave us examples of when they had referred patients living with a disability to support groups and had adapted the patient's treatment to meet their needs. An example of this was the delivery of chemotherapy in a patient's home as they were living with a learning disability and found it challenging to attend a healthcare setting.
- We saw that all leaflets provided to patients by the service could be provided to patients if their first language was not English. These materials could also be provided in braille and audio formats.
- The department had a hearing loop to help those patients using hearing aids.
- Staff were able to tell us how they would access a translator if they needed to.
- The service had access to mental health services if they required additional support for patients with mental health problems.

Learning from complaints and concerns

- Staff told us that they did not often receive complaints but when they did, they were shared anonymously for learning purposes.
- Information on how to raise a complaint was available in leaflet form and staff told us that they provided these to patients as needed.
- Information on how to make a complaint was also outlines in the guide for patients, which each patient received at their first appointment.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint from a patient.
- The trust recorded complaints on the trust-wide system. The service and unit managers were responsible for investigating complaints and undertook these investigations with staff involvement.
- Information about complaints when they were received; was discussed during staff meetings to facilitate learning. Senior staff also told us that they worked with staff individually to address any issues of performance highlighted as a result of a complaint.



We have rated the chemotherapy services as Outstanding in relation to the well led domain because:

- All staff were able to describe the trusts overall vision and values and were able to explain how the service strategy and their role fitted into that vision. The service strategy contained measurable and realistic objectives and outcomes. They also had comprehensive plans for the future and these outlined how the service would be sustained in the future.
- There were robust arrangements in relation to governance arrangements, with clear processes for identifying, recording and managing risks. The risks identified reflected the risks staff front line staff told us about. Progress against these risks was regularly updated.

- There was a strong open culture which was heavily centred on patients and the delivery of high quality care. Staff told us that they felt that their leaders were approachable and visible and they felt comfortable and able to raise issues of concern. Staff felt supported and spoke very positively about their leaders.
- Staff and patients told us that the unit felt like a 'family' and this contributed to a very positive and patient centred culture.
- Staff spoke very positively about the head of service and unit manager with some staff describing them as inspirational. We observed excellent day-to-day leadership and support for staff in meetings and one to one interactions. The chemotherapy senior specialist nurse provided additional leadership support for staff who told us that they valued this and found them supportive and approachable.
- The head of service and service manager were highly skilled and competent in their roles as leaders, led by example, were visible and well respected throughout the service.
- All staff told us that they felt respected and valued in their day-to-day working lives and there was a strong patient centred culture throughout the service. Both staff and managers were continuously striving for excellence and looking for new innovative ways of working
- The service worked effectively and engaged with other professionals to ensure patients received the required level of care and support.
- The service regularly engaged the public in how the trust planned their services. The service was innovative in its approach to the delivery chemotherapy services and other organisations had visited the service to benchmark their practice. The service was piloting a number of innovative projects at the time of the inspection.

Vision and strategy for this service

• The trust had an overall mission statement which was to improve health and wellbeing through compassionate, safe and effective cancer care. This was further elaborated on in the trust vision which was to provide the best cancer care to the people we serve.

- All staff we spoke with were aware of this vision and mission statement and were able to tell us how they felt their role fitted into that vision.
- The trust also had a set of five values that were; putting people first, achieving excellence, passionate about what we do, always improving our care and looking to the future.
- We found that all staff we interacted with embodied these values in their work and were able to outline these to us.
- The service had its own strategy, which was based around the trusts vision, and strategy. This strategy contained measurable and realistic actions and outcomes.

Governance, risk management and quality measurement

- Senior managers within the service told us how they reviewed and brought together different streams of governance to inform risk management, including review of incident and complaints across the service. We saw examples where they had taken actions as a result of reviewing incidents and complaints.
- There were local risk registers for the service that provided robust arrangements for identifying, recording and managing risks. The risks on these registers reflected the risks staff working on the frontline told us about. These risks were regularly updated and leaders were able to tell us what was on the register without checking it.
- The chemotherapy service integrated into the overall trust governance framework and there were appropriate methods of escalating risks and concerns.
- The service used internal audit to monitor quality and drive improvements.

Leadership of this service

- Staff spoke very positively about their leaders. Staff felt supported by their managers and felt able to approach senior leaders.
- Staff spoke very positively about the head of service and unit manager. Some staff told us that they found them inspirational.

- We observed the head of service, unit manager and junior sister providing excellent day-to-day leadership and support for staff in meetings and one to one interactions.
- Staff felt their leaders supported them to form supportive relationships between their team members and other teams.
- The leaders of the service had an open door policy and all staff told us that they felt they were able to go to them with any concerns or ideas.
- The chemotherapy senior specialist nurse provided additional leadership support for staff and staff told us that they valued this and found this nurse supportive and approachable.

Culture within the service

- All staff told us that they felt respected and valued in their day-to-day working lives. Staff told us that they felt the organisation and their managers cared about them.
- There was a strong patient centred culture throughout the service.
- All staff we spoke with said they felt supported by their managers and they would feel comfortable raising any concerns.
- There was a strong open culture which was heavily centred on patients and the delivery of high quality care. Staff told us that they felt that their leaders were approachable and visible and they felt comfortable and able to raise issues of concern.
- Staff and patients told us that the unit felt like a 'family' and this contributed to a very positive and patient centred culture.
- Staff told us they had an open culture and were not afraid of speaking up if they made an error or had a concern.
- Senior managers within the service told us they felt supported by the trust senior management and board members.

Public engagement

- Patient feedback and opinion was routinely sought through service user forums and meetings. Their opinions were taken into account when planning any changes to services.
- All patients we spoke with told us that they felt able to provide feedback on their opinions of their care and treatment.
- Staff routinely sought patient engagement through informal interactions, questionnaires and surveys.
- The service took notice of patient feedback and acted on this to improve services for patients. An example of this was the introduction of the rapid chairs to improve waiting times. This was introduced after patients commented about waiting times for short timed treatment.
- The service also gave out patient surveys to assess whether patients were happy with their care. We saw that managers used this information to improve services.

Staff engagement

- There were regular team meetings that included all staff working in the service and we reviewed minutes from these meetings. Some of these meetings were attended by the head of service.
- There was a daily briefing meeting at the Delamere unit and all staff were required to attend this including staff working at other satellite clinics. This ensured that all staff received important messages and felt part of the wider team.
- The trust also held Schwartz rounds that allowed staff to share stories and discuss cases. (Schwartz rounds are a forum for staff to discuss the emotional and social aspects of caring for patients).
- Staff told us that they were actively encouraged to feedback any issues they have to their leaders. They outlined to us how they would do this either by email or using the incident reporting system.
- Staff told us that they received timely feedback when they raised a concern or an incident.

• Staff told us that they felt that their managers engaged with them in a one to one and team setting.

Innovation, improvement and sustainability

- The staff working in the service worked effectively as a team. They engaged with other professionals and organisations to ensure patients received the required level of care and support.
- The service had comprehensive plans for the future and these outlined how the service would be sustained in the future.
- Staff and managers were continuously striving for excellence and looking for new innovative ways of working, an example of this was the introduction of the rapid chairs in the Delamere unit.The service was piloting a number of innovative projects. One of these was the introduction of the Adjuvant Bisphosphonate service for post menopausal women with a breast cancer diagnosis.

Adjuvant Bisphosphonate ServiceFor post-menopausal women with a breast cancer diagnosis.

- Reduction in recurrence by 17% and overall survival benefit of 3%Zoledronatec service. This service provided 6- monthly IV zoledronic acid for three years for patients with certain types of breast cancer. The service had developed this initiative as research has shown that patients who receive this therapy for three years have a 17% reduction in their breast cancer returning to their bones and an overall 3% reduction in deaths related to breast cancer. The service was one of the first services in England to start providing this service as standard.
- The Chemotherapy at Home project was an innovative project. This development of a community home based service staffed entirely by staff working in the service was the first such kind of service in England. This service allows patients to carry on with their daily lives while receiving chemotherapy.
- The service was also developing community immunotherapy, which linked the services expertise in melanoma immunotherapy, drug safety links and Acute Oncology.

Safe	Good	
Effective	Outstanding	☆
Caring	Outstanding	\Diamond
Responsive	Good	
Well-led	Outstanding	\Diamond
Overall	Outstanding	☆

Information about the service

The Clatterbridge Cancer Centre is one of the biggest cancer centres in the country and treats patients from across Merseyside, Lancashire, Cheshire, the Isle of Man and North Wales.

There are seven linear accelerators for the delivery of radiotherapy treatment at the Clatterbridge site and there is a purpose built unit at Aintree with three linear accelerators. This is a radiographer led unit. The trust delivered 97,926 radiotherapy treatments in the period April 2015 to March 2016. There is a brachytherapy treatment known as Papillon which can provide an alternative to surgery for some rectal cancers. There is a low energy proton beam therapy service for the treatment of cancers of the eye that treats patients from all over the country and from abroad. The low energy proton beam therapy unit is the only one in the country.

The trust will be moving to a new site in the centre of Liverpool in 2018, this will make treatment more accessible for those who live in the more deprived areas of Merseyside and the surrounding areas. Some services will remain at the Clatterbridge site including the proton service for eyes.

We inspected the radiotherapy service at Clatterbridge and Aintree on 7,8 and 9 of June 2016 and on the 21 June as part of the unannounced inspection. At the Clatterbridge site we spoke with three consultants, one specialist registrar and the clinical lead for radiotherapy, four reception/administration staff, four patients and two parents. We also spoke with the business and clinical development manager for radiotherapy, the head of physics, two physicists, three 8A radiographers, four band 7 radiographers, five band six radiographers, the pre-treatment operational manager, three band three radiography assistants, one theatre nurse, a health care assistant and the project lead for the relocation of the hospital to the Liverpool site.

We held a focus group that was attended by 15 therapy radiographers, one diagnostic radiographer, four physicists and one administration staff.

At the Aintree site we spoke with the treatment manager, a band 3 radiotherapy assistant, a consultant, two band 6 radiographers, two band 7 radiographers, two radiography students, one volunteer and the lead for stereotactic radiotherapy.

As part of the inspection we reviewed data and evidence before and after the inspection and during the inspection we spoke with staff and patients and their relatives to collect additional information.

Summary of findings

We rated the radiotherapy service at the Clatterbridge cancer centre as outstanding overall. This was because:

- Services were safe and there was a good and open culture of incident reporting. Lessons were learned and the duty of candour was applied appropriately.
- Patients commented on the cleanliness of the departments and audits were carried out to ensure that equipment was clean. There were infection control processes in place which were also audited.
- The equipment and techniques used for radiotherapy were some of the most advanced in the country.
- There was a comprehensive audit system in place and a culture of continuous learning, development and improvement across radiotherapy and medical physics.
- Staff development was good for all grades of staff and radiographers were taking on new roles that enabled consultants to undertake more complex work.
- Patients were extremely complementary about the service and there were good interactions between staff and patients. Patients and their carers were supported. There was a self- help group for patients who had completed their treatment at the Aintree site and a wide range of complementary therapies were available for patients.
- Patients were given a full schedule of appointments at their first appointment.
- The governance of the department was very effective and the department had participated in an external quality management standard and had done for several years.
- Leadership was robust, which contributed to a culture of improvement and a focus on improving short and long term outcomes for patients.

• The department had consistently achieved their referral for treatment targets though some patients waited more than 31 days to start their treatment. The department cancelled very few clinics.

Are radiotherapy services safe?

Good

We rated the radiotherapy service at Clatterbridge as good in the safe domain. This was because:

- Staff described a good open culture and incident reporting was good. There had been two ionising radiation (medical exposure) regulations (IRMER) notifications to the Care Quality Commission and both had been investigated fully and lessons had been learned.
- Areas were visibly clean and tidy and patients commented positively about cleanliness. There were audits to support the cleaning of equipment following its use on patients with a health care acquired infection.
- Radiographer staffing was adequate at the Clatterbridge site and at the satellite site. There was good skill mix with and an effective management structure. Specialist radiographers were used when appropriate. There was an on call rota for urgent treatment. There were some vacancies in medical physics which were covered by staff working additional hours.
- Safeguarding training compliance for adults and children was at 100% though not all mandatory training compliance met the trust target of 95%.
- There was a mixture of paper records and electronic records for the planning of radiotherapy treatment and some of the consultants were reluctant to move to electronic planning, there was an action plan underway to move all radiotherapy planning onto electronic systems.

Incidents

- The trust was using a paper based system for the reporting of incidents though they were due to move to an electronic system. Completed forms were handed to operational managers at both sites which were forwarded to the governance lead. They looked for trends in incidents; there had previously been an issue with a treatment at the main site that the satellite site was unaware of. Processes were changed and the new operational structure in the department would prevent this from happening again.
- The radiotherapy department had notified the Care Quality Commission about two ionising radiation

(medical exposure) regulations (IRMER) notifications one in 2014 for radiotherapy treatments and one that was recent. These had also been reported as serious incidents under the Strategic Executive Information System (STEIS). The incident that occurred in 2014 had not yet been closed as two other trusts were part of the investigation but were reluctant to provide information about the case. The more recent case involved Papillon treatment, the patient received a greater dose of radiation during the last fraction (treatment) than they should have. This was due to a software problem and the manufacturers of the equipment were immediately informed, they in turn notified other centres across the world about the problem. A software patch has been developed to stop this happening again and the learning from the incident was about the vigilance of the staff during treatment. A letter was sent to the patient with an explanation and an apology from the trust.

- The department worked with colleagues from another cancer trust (oncologist, radiographer or physicist) to support investigation meetings and offer comments, share experiences and generally help them to mitigate against a repeat.
- Incident reporting was good and there was evidence of the use of the duty of candour when appropriate. 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. There was an example of an incident with a patient who lacked capacity and whether they had been consented on the right form, additional training needs were identified and implemented.
- Staff described an open culture for incident reporting and complaints and a no blame culture at the trust.
- The administration staff we spoke with said that they completed incident forms and then passed them on to a manager. Feedback was on a one to one basis with their manager.

Cleanliness, infection control and hygiene

• The environment was visibly clean and tidy and patients commented positively on the cleanliness. We saw staff cleaning equipment and there were clean stickers on the various pieces of equipment. Personal protective equipment was plentiful around the department and in all treatment areas as was hand gel.

- There were audits of the cleaning of equipment, hand hygiene, personal protective equipment, cleaning and decontamination, storage and bare below the elbows. These audits were all at 100%.
- There was an infection control audit tool for treatment areas and theatres. The audit demonstrated the effectiveness of the cleaning process and action plans were completed as appropriate.
- Patients with a known health care associated infection (HCAI) were treated at the end of the day and then the treatment room could be appropriately cleaned. There was an audit of cleaning equipment after use by or on a patient with an HCAI or in a contaminated area and there was 100% compliance in 18 sets of observations.

Environment and equipment

- The department completed environmental risk assessments to identify any shortfalls in compliance with health and safety legislation and the department were compliant in all areas.
- Some of the linear accelerator (linac) treatment areas were open plan and this was being modernised to ensure that information governance was not breached. The trust continued to make improvements to its estate despite the fact that some services were moving to a new site in two years. The radiotherapy manager said that this would continue if it was in the interest of the patients.
- The resuscitation trolleys in the radiotherapy department were checked daily by two radiographers or one radiographer and an assistant. Other machines were also checked weekly including the electrocardiogram (ECG) and the sphygmomanometer for blood pressure. We saw documentation that showed that the trolleys had been completed and checked.
- The brachytherapy suite had a resuscitation trolley that was checked daily. The suite had its own treatment planning area.

Medicines

• Medicines were stored in two lockable drug cabinets with each linac, this was in line with the trust medicines management policy. Forms were available for the radiographers to complete before dispensing the medicines to the patients. Over 80 of the radiographers were patient group directive trained staff and patient group directives were signed by the relevant staff.

98 The Clatterbridge Cancer Centre Quality Report 01/02/2017

Records

- The trust had moved to an electronic patient record two weeks before the inspection. This had caused problems for the administration staff in the radiotherapy department. The system was not suited to giving a schedule of appointments and the administration staff had worked over a number of weekends to ensure that all the patients were migrated over to the new system and that they all had a first treatment appointment. The radiotherapy manager could not praise the administration staff highly enough for their effort and dedication. The information technology department at the trust were adapting the system to make it more useable for the radiotherapy department.
- The department were using an electronic system for oncology information and there were three different electronic systems for planning radiotherapy treatment. Information could be migrated from one system to another. There were plans to move to one planning system and some of the consultants were unhappy about this. It would take some time to implement the new system and it was anticipated that there would be resistance from a number of the consultants. Some consultants were still planning on paper but the trust had a project plan with dates so that each tumour group moved to electronic planning. There was training available for those consultants who needed it. Prostate was the first tumour group to be moved and this was planned for the end of June 2016.
- We saw a radiographer who was working with a patient on their planning appointment; the radiographer checked the name and the part of the body that was to be treated. An explanation of the planning process was given and appointments for treatment were checked. Information was entered onto the computer and a checklist of safety issues was completed. The patient then signed electronically to say that they understood the process.
- The Aintree site was using paper records and there were deliveries of notes twice daily to the site.

Safeguarding

• All of the radiographers and medical physics staff (100%) were trained in the safeguarding of vulnerable adults and 95% to level two for the safeguarding of children and young people. The trust target was 95%. There were small numbers of children who were treated by the

department, these children were accompanied by staff from a neighbouring trust and these staff had level three safeguarding training for children and young people. The paediatric radiographers were never alone with a child though the trust was starting to train appropriate staff in level three safeguarding for children and young people

• The administration staff were trained to level one for the safeguarding of vulnerable adults and children and were 100% compliant with their training.

Mandatory training

- The training records for the radiotherapy staff were currently a mixture of paper records and electronic records, competencies for each member of staff were recorded on the system and the dates when competencies needed to be reviewed.
- The radiographers were not fully complaint with the trust target of 95% for their mandatory training except in safeguarding and manual handling. However in all areas except medicines management they were at or above 90%. This included conflict resolution (93%), equality and diversity (90%), health and safety (92%) information governance (94%) and infection control (90%). The compliance for medicines management training was 68%.
- Most of the mandatory training was done on line as e-learning and the section mangers were involved in the delivery of training of intermediate life support skills. The section managers were also trained in blood transfusion techniques to support patients undergoing radiotherapy while receiving blood.
- The administration staff said that there were regular emails informing them of their mandatory training status.

Assessing and responding to patient risk

- There was a medical emergency team with critical care nurses and the on call doctor if patients became acutely unwell. Patients would be taken to the urgent care centre at a nearby trust.
- There was an on call rota for evenings and weekends of radiographers who could plan and treat urgent cord compressions. There was always a consultant available at weekends. Although some radiotherapy planning was

done manually, urgent treatments were always planned using the electronic planning system. The department felt that using manual planning could be unsafe in these circumstances.

- The assistant radiographers said that if they were concerned about patients they could get the on call doctor to come to see them.
- We observed the treatment of a child who had a general anaesthetic, while being imaged the linac broke down; the team managed the situation well and decisions were quickly made to transfer the child, still under general anaesthetic, to another linac. The team then re-imaged the child and treatment was given.
- There was signage around the department for women of childbearing age or who were breast feeding; there was a procedure for checking the pregnancy status before radiation exposure which was audited. There was 100% compliance with this audit. The department audited compliance with checking the correct identification of patients before commencing treatment, this was continuous monitoring and compliance was 100%.
- There was a World Health Organisation checklist in the brachytherapy theatre and an audit of completion of the checklist. The audit showed that all documentation was completed after each theatre visit.
- At the Aintree satellite site, the staff had protocols for patients who were acutely unwell and worked with the neighbouring acute trust to support these patients as necessary.

Radiotherapy staffing

- Staffing at the Clatterbridge site was adequate with appropriate skill mix and an effective management structure at the band 8B/8A level. There were currently a number of assistant practitioners at band 4 and radiotherapy support workers at band 3. There was some band 2 support in the mould room. Staff rotas showed that on some days the department was understaffed by a small number of radiographers. All senior staff were able to cover on the linacs if necessary and patient appointments were never cancelled.
- Staff worked either 8.30am to 4.30pm or 9.30am to 6.30pm so there were always staff available to ensure that everyone received treatment. This had been a recent change and was unpopular was some staff as it impacted on the on-call rota. Managers said that the new system was safer as previously some of the staff were working long hours.

- Some of the band 7 staff said that they spent more time treating patients than they would have liked and were sometimes unable to undertake the training and development aspects of their role.
- The department was considering job share possibilities and part time working. Staff raised the fact that some staff had job share and others had been turned down, some of this was historical and the manager wanted equity for flexible working opportunities.
- The service manager met with human resources and finance from the trust every two weeks to discuss staffing. The trust had over recruited band 5 staff to address maternity leave vacancies, some staff on temporary contracts had been made permanent and there were opportunities for staff to act up into senior posts while staff were on maternity leave. This was good for staff development. The trust tried to recruit their final year students on placement in the department if they could.
- There was a full complement of scanning radiographers, two band 7's, four band 6's and rotational band 5 and 6 staff. There were six on treatment review radiographers. Skill mix was good in the department with radiographers undertaking some of the routine work that was previously done by specialist registrars and consultants. This left the doctors free to treat the more complex patients.
- There were 16 band 7 advanced practitioner radiographers who looked after a treatment set or a particular area of interest. Some of the radiographers were half time in a specialist role and half time in a treatment role, this allowed staff development and succession planning.
 - There was a clinical workforce strategy which had scoped the current and future demand for radiotherapy and proposed a workforce development plan to meet this demand. This included a range of staff including advance practitioners and specialist radiographers to additional admin and clerical support. The radiotherapy manager said that they were considering a consultant radiographer post for palliative treatment and one for brachytherapy. The current medical director was supportive of consultant posts for allied health professionals. There would need to be extensive training for the role which would need to be overseen and supported by the consultants. It would free up time for consultants and registrars.

- The support workers were trained in care standards and could observe the patients in the waiting areas. Some were trained in phlebotomy and others had received training in the cannulation of patients and the flushing and taking blood from peripherally inserted central catheters (PICC lines). This relieved some of the work pressures from the radiographers.
- There was adequate staffing of medical physics at the Clatterbridge site and physicists rotated into the satellite site to provide cover. There were vacancies at the newly qualified level, some staff were working extra hours to cover this.
- The radiographer staffing at Aintree was adequate as on the day of the inspection there were ten staff and the ideal number would have been 12. The senior staff were permanent (8a's/7's) and the band 5's and 6's were rotational. There was a service delivery lead for the site following a restructure and their role was to develop the service. Staff could be moved from the main site if necessary and the senior 8A staff could cover as necessary.

Medical staffing

- There were 29 clinical oncology consultants, 23 medical oncology consultants and this included a palliative medical oncologist consultant. This was sufficient to cover the population size of 2.3 million. There were five specialist registrars and three registrars. There was also a range of consultants who worked for other trusts and who provided services at Clatterbridge. These included consultant radiologists and psychology medical consultants. The trust was due to appoint a medical oncologist and possibly two posts to support lung cancer treatment.
- We spoke with one of the specialist registrars who said the training was good. Specialist registrars were not allocated to specific consultants.
- At the Aintree site there was medical cover for three half days per week, the doctors would support the radiographers for any off protocol treatment, the clinical lead for radiotherapy said that more medical cover was needed for the satellite centre.

Major incident awareness and training

• There was emergency, contingency and business continuity planning for the trust and the department.

Are radiotherapy services effective?

Outstanding

We rated the radiotherapy service at Clatterbridge as outstanding in the effective domain. This was because :-

- There were protocols in place and treatment was planned and delivered using best practice and national guidelines. The most up to date techniques and technologies were used to provide individualised treatment and to improve the outcomes and reduce the side effects of radiotherapy for patients.
- The radiotherapy department held events to demonstrate advanced techniques in radiotherapy to representatives of other organisations.
- There was a low energy proton beam service for the treatment of eye cancers; it was the only one in the country. There was published data about its effectiveness.
- The Papillon service was providing an alternative treatment to surgery for the treatment of rectal cancers and there was a trial underway to prove the efficacy of the treatment.
- There were excellent comprehensive audit systems in place. The department was using positron emission tomography scanning (PET) and magnetic resonance imaging (MRI) for the planning of radiotherapy treatment. This provides better imaging for the planning of radiotherapy.
- There was a culture of continuous learning and development across radiotherapy and medical physics. Staff regularly contributed to peer reviewed journals and presented posters at national and international conferences.
- There were on treatment review radiographers who following training and a competency assessment were covering the routine work of the consultants and registrars.

Evidence-based care and treatment

• The trust was a reference site for the manufacturer of the linear accelerators (linac's) for image guided radiotherapy (IGRT) so that other trusts and

organisations visited the trust to view the equipment and its applications. Five events were held a year to look at advanced techniques in IGRT with delegates attending from around the world.

- The trust was participating in a number of national audits including bowel cancer, lung cancer, oesophago-gastric cancer, prostate cancer, screening for breast cancer following treatment for lymphoma and audit of toxicity and outcomes of radical chemoradiotherapy in anal cancer. They were also participating in the breast screening after radiotherapy dataset, the radiotherapy dataset and the cancer outcomes and services dataset
- The trust was one of the first three hospitals in the UK to be granted certification after successfully undergoing an independent audit of their stereotactic service. This was a peer reviewed evaluation that focused on procedures and protocols that promoted continual self-assessment and quality improvement.
- There was a low energy proton beam service for the treatment of cancers of the eye, it was the only one of its type in the country and received referrals from the four main eye centres in the UK and internationally. The service treated about 200 patients a year. This accounted for 40% of eye tumours in the UK. Clinicians from across the world undertook training at the centre. There was published data about the effectiveness of the treatment and its side effects.
- The trust were offering Papillon treatment for patients with cancer of the rectum as an alternative to radical surgery. This was a type of contact x ray brachytherapy that was very targeted and involved patients receiving brachytherapy and external beam radiotherapy. The technique was used at ten centres across the world, in the United Kingdom it was offered at three other centres. There was an international group that met annually who had published data that had been submitted to the National Institute of Health and Care Excellence (NICE). The technique had recently been approved by NICE for patients who were not suitable for surgery. There was a randomised trial underway to try to prove the efficacy of the treatment for younger patients who did not want to have surgery. A health economic assessment had also been completed to compare the costs of this treatment against other treatments for the same condition. The consultant leading this work was involved in teaching the technique to others around the world.

- In brachytherapy, the centre was working with colleagues from a trust in the south of the country to develop up to date treatment protocols for planning and treatment. It was likely that these would become national guidelines. Planning was done by computerised tomography (CT) and magnetic resonance imaging (MRI) to give the best imaging for planning purposes.
- The radiographers were using a technique known as co-registration; this involved the overlaying of different image types, MRI, CT and PET to produce a more accurate image for the planning of treatment.
- The department was working to standardise fractionation (dosage of radiation) as there were a number of different doses over different time periods used by consultants. The physics team were working on this standardisation and looking at the best evidence but they said that there was reluctance from some of the consultants to change practice.
- There were tumour group meetings every three months for the consultants, they looked at national guidance and evidence and reviewed protocols and off protocol working.
- At the time of the inspection the United Kingdom radiation oncology conference was being held in Liverpool, a number of staff had posters at the conference. Staff were also presenting posters of their work at the European society for radiotherapy and oncology (ESTRO). One of the consultants had presented a poster at the international symposium on paediatric neuro-oncology in June 2016 on the late effects of radiation treatment. Radiotherapy staff and physicists at the centre had 55 peer reviewed publications since 2013.
- Of the radiographers, 19 had completed their post graduate qualification and 39 others were in the process of completing their post graduate qualifications. All staff above band 7 and a dosimetrist in medical physics had a post graduate qualification.
- Audits had been undertaken to show that the on treatment review radiographer role had saved doctors time allowing them to deal with more complex patients.
- There was a research post for radiotherapy that was four days per week. There was compliance with local in vivo dosimetry protocols and comparisons of these with national requirements.

- The trust was using radium 223 to treat bone metastases from prostate cancer. NICE had issued conditions around the treatment and the department did not know how long they would continue to deliver the treatment.
- There had been an external verification report which said that the throughput for brachytherapy for permanent prostate interstitial implants did not meet minimum numbers and so the department were to discontinue this treatment.

Pain relief

- There were six staff trained in pre-treatment CT scanners who could prescribe Oramorph for head and neck patients who were in pain. They were also undergoing training in the use of Entonox for pain relief.
- Pain relief was discussed at patients' regular reviews with their consultant or their radiographer.

Equipment

- The radiotherapy department at Clatterbridge had some of the most up to date equipment in the country and was used by one of the manufacturers as a reference site to promote and demonstrate their equipment, there were seven linear accelerators (linacs) at the Clatterbridge site and the trust had access to the onsite private linac. The oldest linac at Clatterbridge over ten years old and was mainly used to treat patients receiving palliative care. It was due to be replaced; the trust had an equipment replacement schedule. Some of the older linacs would be replaced when the trust relocated to Liverpool as moving a linac once in situ would be very difficult. There were three linacs at the Aintree site.
- There were two dedicated computerised tomography (CT) scanners for the planning of radiotherapy at Clatterbridge. This was best practice though virtual simulation was available for planning but was rarely used. It could be used at weekends for urgent cord compression treatment.
- Staff said that they were lucky to work at Clatterbridge as they were working "at the forefront of treatment" and that the investment in new techniques and equipment that they were using were reducing side effects for patients.

• At the satellite site at Aintree there were three linacs one of which was for stereotactic radiotherapy treatment. There was a room available at the Aintree site for a CT scanner to enable them to do their own treatment planning in the future.

Nutrition and hydration

- There were nutrition nurse practitioners to support patients who were having radiotherapy treatment. If patients lose weight during treatment then sometimes their treatment prescription needs to be changed as the radiation may not be targeting the right place. This was particularly important for patients who needed to wear a mask during treatment as the mask needed to be tight to ensure that the radiation was targeted in the correct place .If patients lost weight there was a possibility that the mask would need to be remade and the treatment would have to be re-planned.
- The radiographers and nurses used the malnutrition screening tool (MUST) to assess nutrition and hydration for patients.

Patient outcomes

- The department was using new technologies and new techniques in both planning and treatment of radiotherapy. This included image modulated radiotherapy (IMRT) which uses many small beams within a main radiotherapy beam to intersect the tumour from a number of angles. This helped to lower the dose to nearby healthy tissue or organs. Image guided radiotherapy (IGRT) uses a type of three dimensional scanning known as cone beam scanning which is more effective than conventional scanning and fewer side effects are experienced by the patients.
- The NHS commissioning clinical reference group stated that Intensity Modulated Radiotherapy (IMRT) was the gold standard of care and that 33% of all radical treatments should be delivered with IMRT. In the period October to December 2015, 43.1% of all radiotherapy episodes were with IMRT (England average 41%) and in some months had reached 51%. The proportion of all radiotherapy attendances receiving IGRT was 45.4% (England average 45.5%). People were receiving the most effective radiotherapy to improve their outcomes and to reduce their side effects. One of the priorities for the department for 2016/7 was to scan all patients on IGRT capable equipment. The department were using IMRT to treat head and neck cancer, brain cancer, lung

cancer, anal cancer, breast cancer, prostate cancer and cancer of the cervix. If consultants thought that patients with other types of cancer would benefit from IMRT concessions would be given to allow this. The department were doing total skin electron treatment for some skin cancers and total body irradiation to knock out a patient's immune system before beginning stem cell treatment. Although they did not do many of these they had done two in the last three weeks.

- The department could deliver stereotactic radiotherapy, this radiotherapy focused volumetric modulated arc therapy in high doses to the tumour and was used to treat small primary tumours, including lung cancer and metastatic cancers which are cancers that have spread.
- The department was using the deep inspiration breath hold radiotherapy technique for patients having radiotherapy treatment to their left breast; evidence showed that this had better outcomes for some patients as there were less long term effects when using this technique. There had been an investment in equipment and training to support the implementation of this technique following evaluation of the evidence of this technique.
- The Papillion treatment for rectal cancer could provide better outcomes for patients as they did not require a stoma following this treatment though recurrence rates were higher for Papillon compared to surgery. Follow up was thorough following treatment and this offered patients a choice about their treatment. The service was participating in the audit of toxicity and outcomes of radical chemoradiotherapy in anal cancer
- The department was using high dose rate brachytherapy (HDR) for a number of cancers including head and neck cancers; this could give a better cosmetic result for patients and reduce long term effects. It was used as an alternative to surgery for these patients. HDR was also used for certain types of skin cancers and when used with thermoplastic moulds produced a good cosmetic result for the patients. The department were also using it to treat sarcomas in limbs following surgery. The department was starting to use positron emission tomography (PET) scanning to plan patient treatment. The trust had their own PET scanner and was using it to plan treatment for a number of cancers including stereotactic ablative radiotherapy (SABR) for lung cancer which needed very precise planning. The department would soon be doing PET/CT and contrast which meant

that there would be a full planning and diagnostic scan completed at the same time and they were auditing this to look at the cost effectiveness of doing a single scan. This was better for patients as it reduced the number of visits they had to make to the hospital.

- The department used magnetic resonance imaging (MRI) scanning for some planning of treatment to provide better clarity of imaging as necessary.
- The department monitored 30 day mortality for radical and palliative treatment. In December 2015 the mortality rate for radical treatment was 1.04% and in January 2016 was 0.8%. For palliative care in December 2015 the rate was 10.1% and in January 2016 it was 9.7%. The department monitored the mortality rates to ensure that patients received the most appropriate treatment for their cancer
- The on treatment review radiographers (OTR's) developed a clinical management plan for their patients around their radiotherapy treatment and support during treatment and following treatment. This involved supporting patients through the physical and mental side effects of the treatment and helping them to maintain their well-being. They also liaised with other radiographers and supported them during the patients' course of treatment.
- There was an on treatment review radiographer and a trainee on treatment review radiographer at Aintree. We spoke with the review radiographer who had worked on the pilot for the role. She worked for two weeks on the linac and then two weeks in clinic seeing three tumour sites, breast, lung and prostate.
- One of the consultants had an interest in late effects of radiotherapy in children and had given out questionnaires and had conducted interviews with ten patients, they found that patients have forgotten about their treatment five years later and didn't understand why they needed to be followed up. There was a business case to support a one stop shop for late effects where patients would receive input in a number of areas including endocrine, cardiology and psychology to encourage patients to attend. The consultant offered telephone follow up clinics but those patients who wanted to receive follow treatment said that they preferred face to face appointments.

- There were exercise and advice classes for patients receiving radiotherapy for breast cancer, this was to try to reduce the incidence of lymphedema for these patients. There was also a physiotherapy led lymphoedema service.
- There was a specialist paediatric radiographer who liaised and co-ordinated treatment and attended multi-disciplinary team meetings with other children's trusts. The radiographer did the late effects clinic and children were followed up and results collated. She would organise flights and accommodation to the USA if children required proton therapy treatment. She was also trained to take blood from children. There was excellent feedback from parents about this radiographer.
- There was a play therapist at the nearby specialist children's trust who worked with children who had radiotherapy. They built a linac from wood with the child to get them accustomed to the equipment needed to treat their condition.
- Work was ongoing with a proton beam therapy centre in the USA to track outcome data for survival and late toxicity; this would make the case for using proton beam therapy treatment in all children and young people who meet the treatment criteria following the commissioning of the proton beam therapy unit at the nearby specialist cancer trust.

Competent staff

- The Clatterbridge Cancer Centre Final Fellow of the Royal College of Radiologists (FRCR) Part B mock exam were held annually and was attended by UK and International specialist registrars including candidates from Saudi Arabia, France and Ireland. Candidates were in training for their final FRCR exam prior to becoming consultants. There was a replica of the real FRCR exam and the feedback from the candidates was positive, with candidates describing the course as 'the best of its kind in the UK".
- There were radiographers who did the planning and received competency based training with an appropriate post-graduate qualification. Five radiographers were doing the planning following completion of the training and there were two staff in

training. There was some resistance to this at the beginning from the consultants but it was now accepted practice. Planning was done by radiographers and outlining of the tumours was done by the consultants

- The on treatment review radiographers required additional training and additional skills included clinical diagnostics, clinical examination skills and general medicine. They were supervised by the consultants during their training and as part of their role. They were supplementary prescribers but were preparing to be independent prescribers which would save a great deal of time. The on treatment review radiographers were competent in reviewing the treatment of patients with breast, lung and prostate cancer at the Aintree site.
- The paediatric radiographer was on a national working group with other radiographers who treated children.
 One of the radiographers at Aintree was involved in stereotactic radiotherapy, she was presenting with a radiographer from a nearby cancer hospital at a conference.
- We spoke with a consultant clinical oncologist from another trust that came in to perform brachytherapy procedures; she said that the radiographers she worked with were very flexible and willing to learn.
- Induction for new radiotherapy staff was thorough, particularly for staff who had not worked in the department before. Following a period of observation and training on a linac the competencies of the staff were assessed by internal examination. The pass rate was 90%. The examination highlighted where additional training and support was needed and if necessary staff were given a mentor. Many staff who had been recruited had been students in the department.
- We spoke with two radiography students at the Aintree sites who were at different stages of their training, both of them said that the training was very good and any questions were answered well and that explanations about treatment were good. They said that there supervised work was very good as was support from the qualified staff.
- The department had five band four assistant practitioners whose role was becoming obsolete because their scope of practice was limited on the linacs with complex scanning facilities. As the last linac with less complex scanning was due to be decommissioned

in the near future these staff no longer had a role in the department. The trust and health education north west had agreed to fund the training and additional costs so that they can become fully qualified radiographers.

- The physics department undertook the supervision of trainee clinical physicists and provided lectures, projects and assessments for imaging modules for the medical physics MSc at a local university. It was one of two centres in the country that provided this training. Members of the physics team were encouraged to undertake a doctorate degree.
- Radiographers and medical physics staff described good career development in the department.
- There was a study leave committee with the medical physics department who looked at attendance at conferences. If staff had a poster accepted at a conference they were funded to attend, otherwise they were asked to cover half of the costs themselves.
- The manager of the radiotherapy service did the appraisals for the two staff who currently reported to him and in turn they appraised the section managers in the department and this filtered down through the department.
- The administration staff we spoke with had completed their performance development plans and their appraisals.
- The reception staff at Aintree worked on the main reception area and on the treatment areas, they had completed their core standards training.

Multidisciplinary working

- The on treatment radiographers at Aintree said that they had very good rapport with the consultants and sometimes liaised daily by email.
- There were clinical nurse specialists for lung, brain, upper gastro-intestinal, gynaecology and head and neck patients. Radiographers could escalate patients to these nurses if necessary though some nurses saw all the patients having treatment in their speciality.
- There was a combined team of nurses, radiographers, nutrition nurses and dieticians to support patients having head and neck cancer treatment some of these patients had tracheostomies and some were fed by percutaneous endoscopic gastrostomy (PEG)
- Staff said that there were good relationships between medical physics staff and the radiography staff.

- A consultant from North Wales said that multi-disciplinary working at Clatterbridge worked really well.
- Consultants from North Wales participated in the multidisciplinary team meetings at Clatterbridge so that they could crossover and treat other patients if required.

Seven-day services

- The radiography service was working towards six day working and was setting up a focus group to look at the implications for staff and for the equipment. They were looking at different models of working and Saturday working would be useful for stereotactic ablative radiotherapy (SABR) treatment as this took longer than traditional radiotherapy and patients did not have to be treated on a daily basis. This would free up linacs for shorter treatments in the week. Cord compressions could also be treated on a Saturday and not rely on the on-call service.
- There was always a consultant on call at weekend to deal with urgent treatments including cord compressions. Staff would always stay late if necessary to deal with any emergencies and there was an on call rota for the radiographers.

Access to information

- Urgent planning for cord compressions could be done remotely using a laptop with access to the electronic planning system.
- Patient records were available on the electronic patient treatment record and the treatment planning for individual patients was also available electronically. The department was paperlite and was working towards being paper free.
- All the protocols for treatment were available on the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

• Consent was not site specific but the generic consent forms had site specific stickers stating early and late side effects. The radiotherapy manager said that they were considering moving to two stage consent. Patients would be provided with information about their treatment and any possible short or late effects and then would consent to treatment at a later stage when they had considered the information that they had been given.

- There was an audit of compliance with consent to treatment procedure, confirmation to consent and the authority to consent; 100 sets of records were reviewed as part of the audit process. There was also an audit of theatre confirmation to consent. Of these records 54 were radiotherapy records. In 100% of the records the options, risks and benefits of the treatment were discussed with the patient and 100% of the forms were signed by the doctor and the patient. In 70% of records confirmation of consent was signed by the nurse or radiographer who was present at the consent meeting and in 57% of records the patient had been given the appropriate information about the treatment. An action plan was in place to address the gaps in the audit.
- The consultant at the eye therapy centre described an incident when a patient who they were concerned about regarding their capacity to consent and so the patient was consented every time that they attended for treatment following a full description of the treatment and its side effects.
- The radiotherapy manager was considering putting training and protocols in place so that radiographers could take consent. This would speed up the delivery of patients' treatment.
- The department was using a digital signature pad to record consent. Information from this could be used in electronic and paper records.

Are radiotherapy services caring?

Outstanding

We rated the radiotherapy service at Clatterbridge as outstanding in the caring domain. This was because:

- Patients we spoke with said that they were treated as an individual and were extremely positive about the staff and were partners in their own care.
- Counselling services were available for patients.
- All staff in the department treated patients with dignity and respect; they formed strong relationships with patients so that they could support them through their treatment.

- Patients told us that staff helped them to feel safe and secure during treatment
- The importance of supporting carers was recognised as patients needed their support throughout their treatment
- Children attending for treatment were given excellent support to help them to through their course of radiotherapy.
- Volunteers at the Aintree site ran a self- management course for patients who had completed their treatment.

Compassionate care

- All the staff involved in the radiotherapy department were committed to their patients. This included porters, reception staff, administration staff, radiographers and medical staff. They were caring and empathetic towards their patients and treated them all with privacy and dignity.
- In the friends and family test in February 2016, 52 patients said that they were extremely likely and four patients out of a total of 57 patients said that they were likely to recommend the radiotherapy service to friends and family. In March 2016, 99 patients said that they were extremely likely to recommend the service and nine were likely to recommend the service out of a total of 111 patients.
- We spoke with a patient who had an appointment for the planning of their radiotherapy; they had a choice of centre for treatment and had chosen Clatterbridge because of its reputation. They said that their care was excellent and that everyone was doing the best that they could. They told us that everyone introduced themselves by name and that staff knew her name, they said they were treated as an individual. They had been given a lot of information at the start of the treatment about facts and figures and relevant clinical trials which they appreciated.
- Reception staff did their best to accommodate patient's requests for changes of treatment times and dates so they could carry out their normal living activities as far as possible. We observed a receptionist changing appointments to accommodate a patient's prior engagement
- A patient we spoke with said "you couldn't have come to a better place and the staff make you feel secure and safe"

- A patient we spoke with described themselves as very nervous and anxious, that they had travelled two hours for treatment and they had nothing negative to say about their treatment. They said that the staff helped them to be comfortable and less anxious for the procedure. They said that they didn't mind travelling as it was an excellent centre.
- Staff at the eye unit greeted patients by name on arrival at the unit; they had a good relationship with the patients and made them feel as comfortable as they could.
- Administration staff had worked over a number of weekends when the trust moved to the new electronic record to ensure that all the radiotherapy patients had their first five radiotherapy appointments and that their treatment was not delayed.
- Support staff we spoke with said that they built up a good rapport with patients and that they enjoyed the patient contact.
- There were volunteers in the department who gave out free refreshments to patients and their relatives.
- There was somebody selling clothes in the café area of the department on one of the days during the inspection. We were told that patients liked them as they were loose and made of natural fibres and that this was a useful service when patients did not feel well and didn't want to go out. Part of the profits from sales was donated to the trust.

Understanding and involvement of patients and those close to them

- We spoke with the parents of a child who was having radiotherapy; they said that the treatment and care that their child had received was exemplary especially by the specialist radiographer. They felt fully informed and although they had initially felt frightened everyone had gone out of their way to help them feel more comfortable. The child was happy with their treatment and their parents and staff had made a game to get him through the treatment maze to the treatment room.
- Patients attending the eye unit were encouraged to bring someone with them for support. If patients lived more than an hour away the trust covered the costs of a local hotel for patients and their relatives for the duration of their treatment, which was five days. They

used the same hotel and staff at the hotel were aware of the needs of patients and helped to co-ordinate aspects of their care including transport to the hospital site if necessary.

- Patients and relatives said that they were offered refreshments free of charge while waiting.
- There was a bell at both sites that patients could ring to signify the end of their treatment. We spoke to a patient at Aintree who had rung the bell. They were relieved to have finished their treatment but said that their treatment and support had been wonderful.

Emotional support

- There was psychological and emotional support for patients, and staff could refer patients to a consultant. A counselling service was also available. Radiographers could refer to these services.
- As staff saw the same patients every day they were aware of their physical and mental health needs and could support them as necessary.
- There was a Papillon buddy scheme; this was ex-patients who were trained to give one to one support for patients who were considering having Papillon treatment.
- The children who had radiotherapy at Clatterbridge were allowed to choose a laminated poster of their favourite character or game which had numbers on it, these corresponded to the numbers of treatments that the child would receive and, following treatment, the child would place a sticker on the poster that corresponded with the number of treatments that they had received. One of the staff had made a loom band (63 feet long) so that children who were having radiotherapy who were a distance away from their patients could hold onto one end knowing that one of their parents was holding the other end. Children were also given a book that was printed by the centre that they could write, draw or put stickers in to describe their treatment journey.
- The children who needed a mask for their treatment received two masks so that they could take the other one home to get used to it. They could also paint it.
- At Aintree volunteers, some of whom had been patients, organised events and activities for patients to improve their well-being. They ran a six week self-management course for patients who had completed their treatment called help overcoming problems effectively (HOPE).

Patients said that they sometimes felt isolated following treatment and this course helped to support them. There were also other activities including an allotment where patients could get involved.



We rated the radiotherapy department at Clatterbridge as good in the responsive domain. This was because:-

- The reception and waiting areas at both sites were modern and light and airy, at Clatterbridge the main waiting area was set out café style with comfortable seating and coffee tables. The satellite site at Aintree was purpose built and there had been patient input into the design of the building. The department worked with a number of trusts to provide treatment for their patients including a nearby children's trust. They also liaised closely with the nearby cancer hospital on issues such as safety. Eye treatment was provided for patients both nationally and internationally. Radiographers could refer to services in the hospital including physiotherapy, tissue viability, dietetics, and occupational therapy and also services outside the hospital such as social care. There were also a range of services available from MacMillan to support patients on practical matters and their well -being
- Administration staff gave patients a full schedule of appointments at their first appointment following discussions with them to accommodate their preferences. This helped patients to plan their lives during treatment.
- There was a range of complementary therapies available at the Aintree site and a treatment room, they were free to patients. There was peer support for patients who had completed their treatment.

However;

- The department were meeting some of their targets for referral to treatment but were not always meeting their 31 day target for radiotherapy treatment of 100% this was mainly due to head and neck cancer patients who required dental treatment.
- Patients were not always seen within the department 30 minute target, the department had regular meetings to try to resolve this.
Service planning and delivery to meet the needs of local people

- At Clatterbridge the main reception waiting area in the radiotherapy department was set out café style with groups of chairs around small tables. There was a café adjacent to the waiting room though free refreshments were available. Patients then moved from here to appropriate treatment waiting areas for the mould room, pre-treatment and treatment areas, these were light and airy, with comfortable seating. The pretreatment and treatment areas were overseen by a receptionist who could assist with patient enquiries and concerns. They could also monitor patient well-being. Water stations were available in these areas. The waiting area in the mould room was pleasant with comfortable chairs. All areas of the department were air-conditioned. There was a children's play area with good light space and included an outdoor play area for children before they had their anaesthetic.
- The trust had recently purchased a new machine for brachytherapy; it was described as being the best for patient comfort as the treatment times are quicker than for other machines. Two of the radiographers had completed their competency assessments to perform certain procedures in brachytherapy that would save doctor time.
- The radiographers were using vac-bags for some patients including children to help to immobilise them during treatment and to make patients more comfortable. They could be used as an alternative to the tattoos that are used to align patients in the linac before commencing treatment and were less painful and less permanent. They vac bags improved reproducibility of the daily dose of radiation to the correct area. The department was working with the commercial sector to look at production of the bags on a commercial scale. Some patients had an individual head rest made for them as this made them more comfortable during treatment.
- We saw a member of staff explaining pre- treatment imaging to a patient, with an explanation of the use of tattoos as markers and how and why breath holding was better for treatment. The patient then practiced the technique in preparation for treatment.
- One of the radiographers was trained to provide information and support for patients and met with them

following their planning appointment. She could refer to clinical services such as occupational therapy and to services such as benefits advice. Referrals could also be made to social services.

- Patients who required chemotherapy and radiotherapy were accommodated by the department to fit in with their regime of treatment.
- The trust treated about 50 children a year; the younger children had a general anaesthetic before treatment to ensure that they did not move during treatment. There was a general anaesthetic team from a neighbouring trust which included two operating department practitioners, two recovery nurses and an anaesthetist. They attended daily when the child required treatment. Children were treated at the beginning of the day. There was a children's play area and outside space for children when they attended the hospital
- There was a consultant with an interest in neuro-oncology who was involved with children who needed proton beam therapy. She worked closely with the neighbouring cancer hospital that would soon be able to deliver proton beam therapy and said that the paediatric service at Clatterbridge would probably cease when the proton beam therapy came on line.
- The proton eye unit was a purpose built one storey building; patients were greeted at the entrance and shown to a small pleasant waiting room. There was a television and free refreshments. The capacity had recently increased from 190 -210 per year by streamlining processes, patients were seen for five days and had 30 minute treatment slots. The alternative to this treatment was often removal of the eye which was not aesthetically pleasing for patients particularly the small number of children treated by the service.
- The Papillon treatment was an alternative treatment who may have been unfit for surgery, who did not want surgery that involved either a permanent or temporary stoma and who had less advanced cancer. The machine used for the Papillon treatment had recently been replaced with another machine that allowed patients to be treated on their backs, the previous machine required patients to be on their fronts in an undignified position. The machine had been chosen with these considerations in mind to respect the patients' dignity.

- Consultants were moving from single clinician working to tumour group working, this would address issues such as annual leave and job plans for the consultants and speed up planning for patients; radiographers said that this would make things easier for them.
- There was a physics help desk that radiographers could ring in hours if they had a problem with equipment or a patient's prescription for radiotherapy. This meant that all calls were logged and there was continuation in problem solving. Radiographers did not have to go looking for a physicist when they had a problem. The department was considering rolling this service out with radiographer support in the near future.
- In the event of a linear accelerator (linac) breakdown patients could be moved to other linacs as machines were paired. The private linac was used as a contingency in the event of a breakdown as it was not always used to capacity.
- Leaflets about radiotherapy treatment were available in different languages if necessary.
- Many of the radiographers were supplementary prescribers which meant that they could help patients to access medicines in a timely manner.
- There was free wi-fi for patients and their relatives across the trust. There was also free car parking at both sites.

Aintree

- There was a satellite service at Aintree that was radiographer led. The building was purpose-built, with a café and all the waiting areas looked out onto gardens; there was seating in the garden. There was a patient consultation around the design of the building and the theme was "bringing the outside in". There was a treatment room for complementary and pamper therapies, known as the Oasis room and treatments were provided by trained volunteers. The centre had received a grant to convert the room from an office and to provide the necessary equipment and items to deliver treatments and therapies. Patients could access a range of treatments including facials, manicures and pedicures free of charge though many chose to make a contribution. There was a Macmillan office in the main reception area with information for patients and a quiet room that could be used for counselling.
- There was a community room run by a manager from the McMillan service who worked two days a week and a number of activities and services were provided through

volunteers. There was an active volunteer recruitment and training programme. There were arm exercise classes to try to reduce the effects of lymphedema, yoga for exercise and spiritual well-being, an allotment with a "we dig" project and massage to relax the patients.

- The three linacs at Aintree were site specific and one of them delivered stereotactic treatment for palliative patients and right sided treatment for breast cancer. Stereotactic treatment could also be used on benign cancers. One of the other linacs was used for prostates and the third was for deep inspiration breath hold for left breast treatment. All planning for treatment was done at the main site but there was a room dedicated for a computerised tomography (CT) scanner so that staff at Aintree would be able to do their own planning in the future. The centre wanted to start colo-rectal treatment.
- There was a patient connections display poster which demonstrated the contribution of all non-clinical staff to patient care. In addition there were boxes where patients could complete nomination cards for staff awards.

Access and flow

- The referral to treatment times (RTT) for the incomplete pathway (the waiting times for patients waiting to start treatment at the end of the month) were 97.6% in April 2016 and had never fallen below 97% in the period April 2015-March 2016. The target for this was 92%. The 62 day waits (following reallocation) were 93.4% in January 2016, 96.9% in February 2016, 89.5% in March 2016 and 91.1% in April 2016. The target was 85%. This meant that patients who were urgently referred with a suspicion of cancer (two week wait standard) and who were subsequently diagnosed with cancer waited no longer than 62 days for their first treatment.
- However, the radiotherapy waiting times (% treated within 31 days) were not meeting the 100% trust target (NHS target was 96%). In January 2016, 95% of patients were seen in 31 days, in February 97.1%, in March 95.4% and in April 96.8%. This increase in waiting times was due to an increase in demand for radiotherapy treatment and the head and neck patients who required dental intervention as ten days needed to elapse between dental treatment and radiotherapy treatment. These figures also included benign skin cancers that did not require urgent treatment.

- The department cancelled very few appointments, 3.7% in January 2016, 4.2% in February 2016 and 4.1% in March 2016. The target was less than 6%, patients also rarely cancelled appointments with 1.3% in January 2016, 0.9% in February 2016 and 0.9% in March 2016, and this target was less than 3%.
- There was a weekly target meeting to help patients referred to the trust late in their pathway. The meeting was chaired by a manager from radiation or chemotherapy services, it was also attended by a range of individuals including the waiting times facilitator and a booking clerk. There was a report with percentage waiting times which were drilled down to tumour sites and the numbers of patients who were due to breach their target times in the next seven days. Outcomes of the meetings were displayed around the department. The department collected data on patient waiting times, and had set a target of 80% of patients seen within 30 mins. They did not meet this target very often; 69.5% in January 2016, 66.7% in February 2016, 69.5% in March 2016 and 72.6% in April 2016. About half of patients were treated in under 15 minutes, very few waited for longer than one hour. A great deal of work had been done on waiting times and data was available on waiting times for each individual linac. Staff were encouraged to come up with ideas to reduce waiting times which had given them some ownership of the targets. There was a meeting every two weeks to look at patient waits and to remove some of the blocks to treatment. There was a radiographer who contacted consultants to ensure that they had written their prescriptions for radiotherapy treatment and also to ensure that they had consented patients for treatment. If this did not happen treatment could he delayed but it was not a good use of the radiographers' time. The radiotherapy manager wanted to develop training and protocols so that radiographers could consent patients.
- In radiotherapy planning there was a plan to reduce the time from planning to starting treatment. The target in 2015/16 was 10.6 days and the target for 2016/17 was eight days and 2017/18 was seven days.
- Patients were given a schedule of their appointments, including review clinics, at their first treatment appointment. Patients were asked the treatment times that they wanted and staff tried to accommodate this. We saw reception staff changing appointments for patients to accommodate holiday and other events.

- The wait times for each linac were captured electronically and were displayed outside the linac for the patients to see. Staff at both sites would work late if necessary to ensure that all patients were seen.
- Staff described peaks and troughs in patient numbers coming through the department, it was difficult to predict these but when there was a quieter period staff said they could catch up with other work such as audits.
- Patients attending for planning would have their mask made and then a computerised tomography scan (CT) and a magnetic resonance imaging scan (MRI) if necessary on the same day reducing the need for return visits before starting treatment. The department did not have a dedicated MR scanner but had dedicated slots in the MR scanner in the diagnostic imaging department.
- There had been delays for patients in the medical physics department due to late dose checking, the team had looked at the process and made changes to reduce these delays.
- The reception staff co-ordinated patients who needed to use patient transport services. The trust were working with new patient transport providers and staff were concerned that would be dealing with two providers instead of one. The reception staff at Aintree could book patient transport for their patients.
- At the Aintree site one of the linacs was used only for prostate treatment. Staff had audited the length of time needed to treat patients and with the use of the in/out waiting rooms, treatment times had been reduced to 10 minutes from 15 minutes; this has helped to reduce the referral to treatment times for the department. On the days that the linacs were serviced staff worked till 8pm to ensure that patients were treated.

Meeting people's individual needs

- There was a clinical specialist for patients with additional needs who was a point of contact for patients, carers and other healthcare professionals.
 Patients with a learning disability had a health passport to support their care and the trust used "this is me" for patients with dementia. There were also dementia champions in the department to advise staff and to support patients and their carers
- The department was dementia friendly with appropriate signage and lighting, many staff in the hospital were trained as dementia friends.

- There was a trust policy for patients with additional needs and there were alert stickers for paper records. In the electronic planning tool for radiotherapy there was a reasonable adjustment form that would flag up any additional requirements for patients; this was used if patients had a learning disability or other additional needs. An alert for that patient was flagged up when the record was opened.
- Many patients who required head and neck radiotherapy also needed dental treatment before this could start and some of these patients had never had any dental work. There was a dentist who visited the trust twice a week and did extractions. If patients required a number of extractions this could not always be done in one visit. Some patients also required antibiotics. Following dental treatment at least ten days needed to elapse before radiotherapy could begin as the tissues needed to heal; this could result in patients waiting more than 31 days before treatment could begin. The radiotherapy manager said that the dentist was very accommodating and very patient focused.
- Following radiotherapy treatment for patients with head and neck cancers patients were at risk of developing complications in their jaw bone following dental extractions or through fracture of the jaw bone. Patients were given information cards that they could carry at all times that provided information about their condition in case of an accident.
- The trust was introducing the electronic holistic needs assessment (eHNA) from MacMillan. This helped to identify patient concerns such as anxiety about treatment and the financial implications of cancer and allowed staff to develop personalised care plans for patients. These could be kept with the patients records.

Learning from complaints and concerns

- There were very few complaints and these were mostly about car parking and waiting times in clinic. The department tried to deal with complaints verbally and they worked with the patient advice and liaison service in the trust.
- There was a patient experience committee where complaints about treatment were discussed between consultants.

Are radiotherapy services well-led?



We rated the Clatterbridge radiotherapy department as outstanding in the well-led domain. This was because:-

- The department set themselves stretching targets to improve patient experience and patient outcomes.
- The department were required to have accreditation of a quality management standard that required external verification since 1998.
- The department was measuring quality using a quality dashboard and were developing a safety thermometer for the service. Quality was a priority for all staff.
- There were appropriate mechanisms and structures for radiation protection with minutes of meetings going to the health and safety committee of the board.
- Leadership in radiotherapy and medical physics was robust with a culture of continuous learning, quality and improvement.
- Staff were able to challenge each other, including the medical staff and this was encouraged, there was an open culture across the department.
- There was a strategic plan for the trust and a business plan for the radiotherapy department. This included the relocation of the hospital to the new site in Liverpool.
- Staff were proud of their work and liked working in the trust. They also said that it was a friendly place to work. There were some concerns that the culture in the department would not be replicated at the new site in Liverpool.

Vision and strategy for this service

- There was a strategic plan for the trust from 2014-2019; this had been refreshed in March 2016 and included the plans for the move to the new site in the centre of Liverpool. The move to Liverpool would allow closer working with other trusts and to make radiotherapy services more accessible for patients.
- The department set themselves stretching targets to improve services for patients and there was an environment of continuous improvement.
- There was a business plan for the radiotherapy department for 2016/17. All projects and research in the department were derived from the strategic aims of the board.

- Radiography staff said that they knew about the strategy and senior staff in the department said that they promoted it.
- There were vision and values statement boards around the radiotherapy department.
- The vision at the satellite site was to start treating more tumour sites and to do their own planning. There would be more out-patient and review clinics but this would require more medical support. The operational manager said that there was a real feeling of progression for the service and that the vision for the treatment radiographers was that it could be a fully radiographer led service.

Governance, risk management and quality measurement

- Radiotherapy including brachytherapy and the eye proton service was part of the radiation services directorate; this also included diagnostic imaging.
- There was a process in place for the dissemination, review, implementation and monitoring of all clinical guidance including guidance from the National Institute for Health and Care Excellence and protocols and radiation (medical exposure) regulations (IR(ME)R). This formed part of the quality and risk standards and was audited annually. Each NICE guidance was allocated to an appropriate clinical lead by the director of nursing and quality and monitoring of completion of the review and implementation of the guidance was done through the clinical directorate performance review meetings every three months
- The radiotherapy department had maintained accreditation of ISO 9001: 2008 with BSI since 1998. This was a quality management standard and the department was audited every year by an external verification body. The standard also required a robust system of internal audit. In 2007 The Clatterbridge Cancer Centre achieved accreditation Trust wide for this quality management standard.
- The department were using a service specialised quality dashboard; the dashboard was divided into sections of outcomes, safety, experience, activity and productivity with targets in each section and was well populated. They were also developing a radiotherapy safety thermometer to measure, monitor and improve their service.

- The department monitored their treatment errors so that they could identify any issues or trends; this was measured as the number of errors per 1000 fractions. In January 2016 there were 1.16 per 1000 fractions and in February 2016 there were 1.35 per 1000 fractions.
- There was a directorate risk register with review dates; risks included the medical cover at the satellite centre and failure to meet targets including the 31 day target due to an increase in demand for treatment.
- Radiation protection was part of risk management in • the trust. The health and safety committee was attended by the directorate manager and the minutes of the radiation protection meeting were circulated to the committee. There was a radiation protection supervisor's forum, the terms of reference stated that it was a forum for issues of concern and the mechanism to feed information to and from the health and safety committee. There was representation on the forum from medical physics, and radiotherapy. Once every year the forum meeting was designated the radiation safety committee meeting and the appointed doctor, the health and safety advisor, the trust radiation protection advisor, clinical directors who used radiation and a representative from the approved dosimetry service were invited to the meeting. We saw the minutes of the meeting.
- There were staff meetings every three months which were held at 12pm and 1pm to allow all radiographers to attend. This was repeated at the satellite clinic. Staff were not able to stop work to attend meetings or patient treatment would have been compromised. The department also produced a monthly newsletter- the "radiotherapy times" with five sections that reflected the domains of CQC.
- There were monthly meetings between the managers and the 8A radiographers. The 8A staff then met with the band 7 staff informally to pass on information. This was disseminated through the department. Treatment radiographers met monthly though anything urgent was circulated at the beginning of the day.
- There were weekly operational meetings with medical physics and radiotherapy which were attended by the clinical director.
- There was a governance radiography lead who produced monthly reports on incidents for the board.

Leadership of service

- The leadership of the radiotherapy service was robust and effective; the head of the department and the operational managers were a cohesive, responsive and effective team. There was a culture of continuous improvement, quality and learning that was reflected throughout the department. The radiotherapy staff wanted to improve patient outcomes and experiences and worked with colleagues to develop themselves and the service. Leadership in medical physics was also outstanding and the two departments worked with medical colleagues to deliver the radiotherapy service. There was strong leadership from the clinical director for radiotherapy who was working with the consultants to bring about the necessary changes to improve the service.
- The manager of the service had recently completed a leadership course which involved working with a local car manufacturing site. This had provided a number of ideas for improvements. One of these was boards in a corridor that was frequently used by staff to highlight current research, projects and ideas with completion dates. They gave a visual representation of all research and innovation in the department.
- Staff at the Aintree site said that senior management made the effort to be visible. They also said that they looked at the chief executives blog.

Culture within the service

- The radiotherapy service manager said that they were trying to define their culture before the move to Liverpool and although the service had to deliver a very precise technical treatment to patients, they were treated as individuals. Staff were also concerned that they may lose the "nice work atmosphere" that they had at Clatterbridge.
- A consultant we spoke with said that she was very lucky to be working at Clatterbridge and radiographers we spoke with agreed with this.
- Radiographers said that they were proud of the quality of their work, and another said that her role was very empowering. A number of staff had left the trust and then returned. They said it was a friendly place to work.
- Physics staff described a culture of innovation and encouragement for staff to develop projects. They also said that they were able to challenge decisions made by doctors and that this challenge was healthy and well received. Team working was good in the department.

- The pre-treatment radiographers described close working with consultants and described them as approachable; the treatment staff did not see the consultants as often. Support staff said that they had good relationships with the consultants who would ask the staff for updates on the patients' well-being.
- The administration staff at Clatterbridge had been nominated for a staff award by the radiotherapy manager following their work to transfer all patients from one electronic system to another. This ensured that there were no gaps in patients treatment.

Public engagement

- A patient had volunteered to be in a video of the patient's journey through rectal cancer and having Papillon treatment.
- A patient who had complained about treatment waiting times had been invited to join a group at the trust and had used his experiences in the manufacturing industry to streamline processes.
- There were slips available on the reception desk in the main waiting area with "what can we do to improve our service" and "please let us know what you think we are good at". When the patients had filled them in they were pinned to a board in the reception area. The department had only been doing this for three weeks and so had not had time to collate the responses. All the comments that we saw were positive. The radiotherapy manager said that they sometimes had problems getting people to fill in the friends and family survey and were using this as an alternative method of gaining feedback from patients.
- There had been consultation with the public about the move to Liverpool with presentations

Staff engagement

 The section managers were going to start one to one meetings with the lower banded staff every two to three weeks. The trust was moving to a new site in the centre of Liverpool and most services would be based at that site although some would remain at the current site. Some of the staff were concerned about the move and the new facilities. The one to one sessions would allow staff to voice concerns about this and any other issues

that were affecting their work. There had been presentations to all staff about the new site and meetings to which all staff had been invited. The project lead for the move was a radiographer

- There was a transforming cancer care team who came to speak to the staff and patients at Aintree about the new site in Liverpool.
- There were keep in touch days for staff who were off on maternity leave and time off set days when staff were not rostered for patient treatment.
- There were two fifteen minute breaks for radiotherapy staff morning and afternoon and an hour for lunch. This reflected the levels of concentration needed to deliver this service and the trust support to ensure that staff were rested during the day.
- The staff room at Aintree was well decorated in the same style as the rest of the building with area to prepare and eat food and an area with comfortable seating for staff. This gave staff a chance to relax in their break times.

Innovation, improvement and sustainability

- The department had a list of improvement initiatives that that they were implementing in 2015/6 These included the development of a weekly palliative clinic, the deep inspiration breath hold for left sided breast patients, waiting times initiative, review of the dose calculation pathway, electronic prescribing of radiotherapy for all patients, the migration of all planning to the electronic system and the development of the stereotactic ablative radiotherapy service
- The department set themselves challenging targets to improve outcomes for patients; this meant that services continually improved.

Outstanding practice and areas for improvement

Outstanding practice

End of Life Service

- The service had developed a simulation based training programme to develop the skills and knowledge of staff throughout the hospital. This involved simulating difficult situations so that staff developed their confidence when dealing with patients and relatives at the end of life.
- All staff were committed to facilitating the requests of patients at the end of life. For example, there had been a number of weddings organised within a short period of time at the request of patients. Several staff were involved in facilitating these.
- The service had responded to NICE guidance by developing a day after death service which met the needs of the bereaved in that a number of risk assessments were undertaken to ensure their welfare.
- The SPC consultant was involved in a number of projects. For example, the serious illness programme UK was being piloted alongside a number of organisations from the United States of America and had been designed in response to services recognising the challenging situations that clinicians faced when dealing with patients and relatives at the end of life.

Outpatients and Diagnostics service

 Individual needs of patients were identified through completion of a Holistic Needs Assessment at varying times during treatment and surveillance.
Following completion a care plan was formulated to summarise any concerns and identify actions to address them.

Radiotherapy service

- The development of the advanced practice radiographer posts that enabled consultants and registrars to do the more complex work.
- The uses of skill mix across the department for staff at all levels including health care assistants

- The continuing development of the Papillon service as an alternative to radical surgery.
- The proton beam service for the treatment of eye cancers and its continuing development and training of staff from other centres.
- Radiographers able to dispense medicines under patient group directives for head and neck cancer patients to alleviate their pain.
- The development and use of the vac bags to help to immobilise patients during treatment and the making of individual head rests to make patients more comfortable.

Chemotherapy service

- The innovative introduction of the rapid chair initiative in the Delamere unit had improved the experience and waiting times for patients receiving shorter treatments.
- The introduction of the Adjuvant Zoledronatec service was innovative and market leading the introduction of this service meant that patients with breast cancer were receiving the very latest evidence based treatment to reduce their risk of death and reoccurrence.
- The Chemotherapy at Home project was outstanding and provided patients with treatment in their own homes. This service embodied the overall trust and service vision of providing the best cancer care to their patients.
- The positivity and compassion shown by staff and reflected in the feedback from patients was outstanding. It was clear that all levels of staff continuously strived to provide outstanding care to their patients.
- The interaction and utilisation of the Maggie's Merseyside charity was excellent. It meant that patients could access all the advice, support and treatment in one place at one time.
- The support offered to patients throughout their treatment was outstanding. This included the

Outstanding practice and areas for improvement

implementation of the end of treatment bell, the PAT therapy dog and handler, massages and relaxation

techniques for patients and the program of activities provided in the Maggie's centre. All of which contributed to patients receiving an excellent level of emotional and practical support.

Areas for improvement

Action the hospital MUST take to improve

In outpatients and diagnostic imaging;

- The hospital must improve the staffing establishment and the professional leadership of the radiology department including the modality lead posts as PET/CT and nuclear medicine were the only speciality with a filled position.
- The hospital must ensure the radiation protection and safety aspects within the Trust are addressed and documentation kept up to date.
- The hospital must improve the quality assurance processes in the diagnostic imaging department. Ensuring it is appropriate and timely.
- The hospital must ensure review and update of all policies and procedures surrounding radiation protection in the imaging department to ensure they reflect current practise.

Action the hospital SHOULD take to improve

In outpatients and diagnostic imaging;

- The hospital should ensure cleaning checklists are consistently completed in the outpatient department.
- The hospital should take steps to ensure that resuscitation equipment is checked in line with trust policy.
- The hospital should ensure paper medical records have entries that are legible and completed as per trust policy.
- The hospital should ensure mandatory training is completed as required including safeguarding training.
- The hospital should ensure Mental Capacity Act training is completed as required.

- The hospital should ensure that training records for CT radiographers are kept up to date to reflect new techniques or equipment updates.
- The hospital should improve the vision within the diagnostic imaging team through strengthening the professional leadership of the department.
- The hospital should improve the professional development of diagnostic radiographers.
- The hospital should ensure that appraisals of staff are carried out regularly in diagnostic imaging.
- The hospital should ensure there is appropriate MRI service planning.

In oncology services

- The trust should ensure that sharp instruments and records are kept secure and not accessible to patients and the public.
- The trust should ensure that all staff report incidents in a timely way
- The trust should ensure that patient records are stored securely
- The trust should ensure that all patient assessments are fully completed.
- The trust should encourage medical staff to attend the weekly MDT meeting on Conway ward
- The trust should ensure that the dementia strategy is fully embedded in services.
- The trust should ensure that actions on the risk register have an identified timeframe.
- The trust should ensure that plans to implement further seven day services are implemented
- The trust should ensure that staff are up to date with all mandatory training especially in infection control and life support.

In End of Life Care

Outstanding practice and areas for improvement

- The management team should ensure that the quality of the mortuary is continually monitored as part of the service level agreement. This should be in line with the terms and conditions that have been set out as part of the agreement.
- Consider how end of life services will be effectively transferred to the new hospital that is going to be built and be opened in 2019.
- The service should ensure that all staff receive the required standard of mandatory training.

In Chemotherapy

- Consider how paper based incident report forms are stored once completed so that the anonymity of staff completing them is maintained.
- The management team should consider how incidents and complaints are recorded in governance meetings so that accurate records of discussions are kept.
- The service should consider taking part in the gold standards framework accreditation scheme.

- The service should consider implementing the palliative care electronic records system so that records and patient information can be accessed by other services.
- The service should ensure full implementation of the trust-wide dementia strategy that has been developed on all inpatient wards.

In Radiotherapy

- The radiotherapy department should improve their mandatory training compliance
- The radiotherapy department should move to electronic planning for all radiotherapy treatment as soon as possible.
- The radiotherapy department should consider site specific consent for all tumour sites.
- Staff working with children should be trained to level three in safeguarding for children and young people.

Requirement notices

Action we have told the provider to take

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

Regulation
Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed.
Regulation
Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (b) Systems and processes must be established and operated effectively to assess, monitor and mitigate risks relating to health, safety and welfare of service users and others who may be at rick which arise from the carrying