

LOC@Chelsea

Quality Report

102 Sydney Street
London
SW3 6NR
Tel:0203 131 5927

Website:<https://www.hcahealthcare.co.uk/facilities/leaders-in-oncology-care/contact-us/loc-at-chelsea> Date of inspection visit: 11 June 2019
Date of publication: 31/10/2019

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

Ratings

Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Outstanding 

Are services well-led?

Good 

Overall summary

The LOC @ Chelsea is located in Chelsea, is easily accessible by public transport, and provides outpatient cancer treatment and oncology outpatient consulting. LOC @ Chelsea is operated by Leaders in Oncology Care. The service has 15 treatment bays, with two side rooms. Facilities include four consulting rooms, on site oncology pharmacy and aseptic suite, phlebotomy rooms, laboratory and a Positron emission tomography-computer tomography (PET CT) scanner.

The service aims to provide a 'one-stop' service for its patients including consultation, diagnostic tests, treatment and supportive therapies in one location.

More than 75 cancer specialist consultants practice from the LOC sites. The service holds specialist clinics on different days of the week including clinics for lung cancer, breast cancer, melanoma and the service

Summary of findings

provided psychological support clinics each Tuesday. The service had a supportive services team (complementary therapists, hair / image specialists, dieticians, etc.) available.

The service provides medical care and diagnostic imaging. We inspected medical care and diagnostic imaging.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 11 June 2019. We gave 24 hours' notice of the inspection because evidence gathering in an unannounced inspection would be affected by the fact that the service has other sites within the provider and not all staff would have been on site.

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

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

This was the first time we rated this service. We rated it as **Outstanding** overall.

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough medical and nursing and radiology staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available six days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Summary of findings

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
 - Staff provided emotional support to patients and families to minimise their distress.
 - Staff supported and involved patients and families to understand their condition and make decisions about their care and treatment.
 - The service planned and provided services in a way that met the needs of the patients it provided services to.
 - The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
 - People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were within service targets.
 - It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
 - Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
 - The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.
 - Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
 - Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
 - Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
 - The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.
 - Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
 - All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.
- However:
- Not all staff were not confident in accessing policies via the intranet. Some staff could not show us where to find key documents.
 - Patients could not tell the difference between different staff members by grade as uniforms were ambiguous and not explained.
- We found areas of outstanding practice in medicine:
- Staff worked especially hard to make the patient experience as pleasant as possible. Clinical Nurse Specialists recognised and responded to the holistic needs of their patients. Staff went above and beyond for their patients.
 - Despite the outpatient nature of the service, the service provided a plethora of complementary therapies, from reflexology to massage to assist patients with symptom management.
 - The on-site phlebotomists, pharmacy and aseptic suite meant that the service offered a one-stop shop and patients rarely had to wait.
 - Data provided showed that 100% of PET CT and CT scans were reported within 24 hours (July to December 2018).

Summary of findings


Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals for London and the South

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Outstanding 	Medicine was the main activity of the hospital. Where our findings on medicine also apply to other services, we do not repeat the information but cross-refer to the medicine section. We rated this service as outstanding because it was safe, effective and well-led, although caring and responsiveness was outstanding.
Diagnostic imaging	Good 	We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

Contents

Summary of this inspection	Page
Background to LOC@Chelsea	8
Our inspection team	8
Information about LOC@Chelsea	8
The five questions we ask about services and what we found	10
<hr/>	
Detailed findings from this inspection	
Overview of ratings	14
Outstanding practice	41
Areas for improvement	41
<hr/>	

Outstanding



LOC@Chelsea

Services we looked at

Medical care and Diagnostic imaging.

Summary of this inspection

Background to LOC@Chelsea

LOC @ Chelsea is operated by Leaders in Oncology Care. Leaders in Oncology Care (LOC), part of HCA Healthcare UK, was set up by four cancer specialists to with the ambition of providing care and treatment, according to recognised best practice. Initially a single clinic, the service expanded its facilities and services to meet the needs of patients, consultants and evolving treatment options.

The provider opened LOC @ Chelsea in May 2017 and primarily serves the communities of London. It also accepts patient referrals from outside this area and treats a vast number of international patients.

The service has 15 treatment bays with two side rooms, four consulting rooms, a blood laboratory, an on-site pharmacy and PET/CT scanner services.

This is the first time we have inspected the service.

The hospital has had a registered manager in post since May 2017. At the time of the inspection, there was an interim manager, and this was known to the CQC.

We carried out an unannounced inspection on 11 June 2019.

Our inspection team

The inspection team comprised a CQC inspection manager and lead inspector, one other CQC inspector,

and two specialist advisors with expertise in oncology and diagnostic imaging. The inspection team was overseen by Terri Salt, Interim Head of Hospital Inspection.

Information about LOC@Chelsea

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.

Medical care is the main service delivered at the service and was carried out on the third and fourth floor of the building. The main activity under medical care was systemic anti-cancer therapy (SACT). The SACT service included all the preparations for giving chemotherapy and other medicines to treat cancer. Chemotherapy was either given directly into the vein through Intravenous Therapy (IV), as an injection under the skin, into the spinal area or as a tablet.

Diagnostic imaging was the second largest activity carried out at the service and was carried out on the ground floor. The service imaging suite provided three types of images for patients. Images carried out included Positron

emission tomography-computer tomography (PET CT), dynamic Positron emission tomography-computer tomography (dPET CT) and Diffraction Contrast Tomography (DCT).

The third largest activity carried out at the service was symptom control. This included the management of a patient presenting with symptoms/side effects of SACT such as nausea, vomiting, dehydration and constipation.

In the year prior to our inspection, the activity levels at the service were as follows:

- Systemic therapy: 1260 (IV) and 95 (oral).
- Diagnostic imaging: 902 images.
- Symptom control: 372 interventions.
- Central venous access devices (CVAD) flushes/disconnection: 199 procedures.

Summary of this inspection

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the hospital's first inspection since registration with the CQC.

Over the course of our inspection we inspected the 15 treatment bays, the blood laboratory, the pharmacy and the diagnostic imaging services. We attended one multidisciplinary team meeting (MDT) and interviewed key members of staff.

We spoke with 20 members of staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with eight patients and one relative. During our inspection, we reviewed six sets of patient records.

There were 75 doctors who worked at the hospital under practising privileges. This meant the provider was assured that the consultants had the right qualifications, skills and experience which were necessary for the work performed by them. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic or in independent private practice. One regular resident medical officer (RMO) worked on a daily rota. The service employed six registered nurses and three healthcare assistants. There was an accountable officer for controlled drugs (CDs) in place.

Track record on safety

- Zero Never events
- 52 clinical incidents: 35 no harm, 17 low harm, zero moderate harm, zero severe harm and no deaths.
- Zero serious injuries.
- Three incidents involving ionising radiation. Zero met the criteria of reporting under Ionising Radiation (Medical Exposure) Regulations.
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli.
- Two complaints.

Services provided at the hospital under service level agreement:

- Housekeeping, cleaning, laundry and catering.
- Fridge monitoring.
- Reception, administration, portering, waste management, telecoms, catering, estates and maintenance, security, medical gases, materials and purchasing.
- Pathology.
- Medical devices maintenance.
- Scalp cooling system.
- Radioactive materials.
- Courier services.
- Interpreting services.
- Pharmacy clean room.
- Pharmacy aseptic service computer software.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Are services safe?

This is the first time we have rated this service. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough medical and nursing and radiology staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

Good



Are services effective?

Are services effective?

This is the first time we have rated this service. We rated it as **Good** because:

Good



Summary of this inspection

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available six days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

However:

- Staff were not confident in accessing policies via the intranet.

Are services caring?

This is the first time we have rated this service. We rated it as **Outstanding** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff went above and beyond for their patients.
- Staff provided emotional support to patients and families to minimise their distress. They came up with innovative ideas to support their patients.
- Staff supported and involved patients and families to understand their condition and make decisions about their care and treatment.

However:

- Patients could not tell the difference between different staff members by grade as uniforms were ambiguous and not explained.

Outstanding



Summary of this inspection

Are services responsive?

This is the first time we have rated this service. We rated it as **Outstanding** because:

- The service planned and provided services in a way that met the needs of the patients it provided services to.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. Specialists recognised and responded to the holistic needs of their patients.
- Despite the outpatient nature of the service, the service provided a plethora of complementary therapies, from reflexology to massage to assist patients with symptom management.
- The on-site phlebotomists, pharmacy and aseptic suite meant that the service offered a one-stop shop and patients rarely had to wait.
- Data provided showed that 100% of PET CT and CT scans were reported within 24 hours (July to December 2018). People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were within service targets.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Outstanding



Are services well-led?

This is the first time we have rated this service. We rated it as **Good** because:

- Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Good









Summary of this inspection

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	Outstanding 	Outstanding 	Good	Outstanding 
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Outstanding 	Outstanding 	Good	Outstanding 

Medical care (including older people's care)

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

Are medical care (including older people's care) safe?

Good 

This is the first time we rated safe for this service. We rated it as **outstanding**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Mandatory training was provided to staff in the following subjects: basic life support (BLS), ethics and code of conduct, moving and handling, HCA equality and diversity, Safeguarding children level 2, health and safety, PREVENT, infection control & sepsis, safeguarding adults level 2, GDPR, Duty of Candour (DOC), Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DOLs), dementia and safeguarding children level 1a.
- Mandatory training was provided annually to staff through a mix of both classroom and online sessions. Training was monitored by heads of departments monthly through the automated reports produced by the provider learning academy.
- At the time of the inspection, the mandatory training figures for staff met the organisation's 85% target for completion with rates of between 91% for BLS and 100% for safeguarding children 1.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

- The hospital had clear systems, processes and practices to safeguard patients from avoidable harm, abuse and neglect, that reflected relevant legislation and national requirements. Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse.
- Staff told us if there were any safeguarding issues they were usually picked up during the initial visit or when attending an outpatient appointment. Staff were aware of the trust policy and knew they could escalate to the safeguarding team at any time.
- At the time of our inspection 93% of staff had completed safeguarding children level two and 97% of staff had completed safeguarding adults' level two. This was in line with national guidance. At the time of our inspection, 96% of staff were trained in PREVENT. The service did not treat anyone under 18 years of age.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- The service had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this as part of their rolling training programme. At the time of our inspection, 96% of staff had completed this training.
- The provider took oversight of monthly meetings and the service had a link IPC nurse that attended those



Medical care (including older people's care)

monthly meetings. Link nurses act as a link between the service and the provider infection control team. Their role was to increase awareness of infection control issues and motivate staff to improve practice.

- We found all areas (both clinical and non-clinical) to be visibly clean. All clinical areas were cleaned between patients. We spoke with housekeeping staff and reviewed cleaning logs and found no environmental issues that could potentially present an infection risk. We inspected treatment bays and found them to be clean and well maintained. A cleaning audit for April 2019 found 100% compliance with internal standards. The aim of the audit was to ensure correct infection controls were in place and that staff were following them.
- All the patient bays were single occupancy. There were two private side rooms for patients requiring isolation.
- We saw there was access in all areas to hand washing facilities, hand sanitiser and supplies of personal protective equipment (PPE), which included sterile gloves, gowns and aprons. All staff adhered to the bare below the elbows policy. We saw the service hand hygiene audits and found that they regularly achieved 100% in compliance. This was corroborated by our time at the service when we found all staff complying with sound hand hygiene techniques.
- The service screened all patients for MRSA prior to admission, in line with Department of Health guidelines. MRSA is a bacterium that can be present on the skin and can cause serious infection. The service screened all new admissions for MRSA on the first visit and every month following throughout the course of treatment. We saw that patients with MRSA were treated in side rooms.
- In the 12 months prior to our inspection there were zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli
- We saw safe systems for managing waste and clinical specimens during inspection. Each patient bay had its own sharps bins which were all used appropriately. Throughout clinical areas, all sharps bins were dated, signed and not overfull. The sluice area was clean and contained separate disposal pathways for clinical waste and chemotherapy waste.

Environment and equipment

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

- The treatment suite and consulting rooms were located on the same floor. The treatment suite consisted of 15 pods with two side rooms.
- Equipment used on the treatment suite was clean and labelled to indicate it was disinfected and ready to use. Disposable equipment was easily available, in date and appropriately stored. All portable equipment we checked had been recently serviced and labelled to indicate the next review date. We reviewed equipment logs and saw that equipment used was due to be serviced according to manufacturer's guidelines.
- Resuscitation equipment was available on the unit with grab bags being available near the consulting rooms. Emergency drugs were available and within use by date. Nursing staff carried out appropriate daily and weekly checks to demonstrate that all equipment was safe and fit for use.
- We saw a resuscitation audit for April 2019 and found that the service had 100% compliance with the corporate resuscitation policy. The resuscitation equipment on the treatment suite was checked every operational day.
- In the sluice, we saw cytotoxic waste separated into a separate waste bin and closed at the fill line. The bins were stored in a locked waste room until collected by porter staff for disposal. Staff were aware of the process and policy for cytotoxic spillage and contamination and could demonstrate knowledge of what to do and who to contact if needed.
- All staff were trained to ensure competency in cleaning of a cytotoxic spill. We were informed that couriers were trained by pharmacists at the service to ensure that they would know what to do in the event of a spill. The service had a policy for cytotoxic spills which detailed the process staff should follow in the event of a cytotoxic spill.

Assessing and responding to patient risk

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

- The service had pathways for each patient group that it treated. Within the pathways were exclusion and



Medical care (including older people's care)

inclusion criteria. In all patient pathways, the decision to treat was left to the discretion of the consultant. The consultant would not accept referrals from severely unwell patients.

- We saw that there was a robust sepsis training programme to ensure that staff were able to appropriately deal with signs of sepsis. Sepsis was included as part of the mandatory training programme and 96% of staff were trained in it. The clinical practice facilitator (CPF) was also the service sepsis lead. The CPF provided refresher training sessions on sepsis throughout the year.
- The service had developed a management of suspected febrile neutropenia in adult patients' policy with an algorithm for staff to follow. We reviewed this policy and found that it followed the national Sepsis 6 flow chart.
- The service had a training programme to ensure appropriately safe checks at all stages were carried out before therapy was delivered intravenously. In the 12 months prior to our inspection there were no incidents reported of systemic anti-cancer therapy (SACT) being given via the wrong route.
- Extravasation is the leakage of intravenously (IV) infused, and potentially damaging medications into the extravascular tissue. We spoke with the Resident Medical Officer (RMO) about what to do in the event of extravasation. They informed us that whilst they were trained to deal with the signs and symptoms of extravasation, they could call the consultant if in any doubt. Since the service opened, there had been no extravasations.
- In the event of a patient deteriorating, the patient was transferred to a local NHS trust. The service had a service level agreement with a trust for this. Out of hours, the patient could call the 24-hour triage line that was staffed by specialist triage nurses. The triage nurse could make a judgment over the phone as to whether the patient should attend A&E.
- The service used central venous access devices (CVAD's) to deliver chemotherapy. A CVAD is a catheter that is inserted into the central venous system. Each month, the service carried out an audit to assess CVAD compliance with the Health & Social Care Act and inform staff of non-compliance. Non-compliance would be, for example, if a patient wasn't adequately educated on post CVAD insertion. An audit carried out in January

2019, showed 97% compliance in continuing care of CVAD. Learning from this audit included reminders to nursing staff to document that they have taught patients how to care for CVADs and the complications of CVAD's.

Nurse staffing

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

- The service had clinical nurse specialists (CNS) for each major cancer group, this included the following: breast, gynaecology, gastro intestinal, neuro oncology, lung, urology, haematology and radiotherapy.
- There were five nurses and one healthcare assistant (HCA) employed by the service. Within this group there was 3% sickness rate and no vacancies.
- The 24/7 triage line was staffed by a registered nurse who followed the UK Oncology Nursing Society (UKONS) triage tool.

Medical staffing

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

- There was one Resident Medical Officer (RMOs) with no sickness, vacancy or turnover. The RMO worked on a weekly basis and then swapped with an RMO from another HCA facility. There were four RMO's in total who worked like this. All RMO's were trained in line with national guidance and had cancer expertise.
- The hospital worked with consultants through a practising privileges arrangement. Consultants were granted practising privileges after scrutiny by the medical advisory committee (MAC). The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Consultants were invited to join the staff at the hospital following identification of suitability and discussion at the medical advisory committee.
- There were 75 consultants with practising privileges at the time of our inspection.
- All patients were admitted under the care of a named consultant, who managed the care of their patients.



Medical care (including older people's care)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

- The service used an electronic system to keep patient records. The system was co-designed by the provider and LOC clinicians to prevent errors and allow for all steps in the pathway to be e-verified so that no intervention happened to the patient without it being appropriately checked and captured.
- We observed a patient record audit dated August 2018 and found that the service was 82% compliant with local standards. The goal compliance rate was 90%. The service began a process of re-education and quarterly records audits. We saw the patient record audit for the month of April 2019 and found that the service was 100% compliant with local standards.
- We reviewed five sets of medical notes and found that these complied with General Medical Council (GMC) standards for documentation. All records we viewed had a diagnosis and management plan and risk assessments were documented where applicable for nutrition, VTE, and pressure ulcer. Records included documentation of patient symptom control and observations during SACT.
- Records we reviewed contained evidence of Multi-Disciplinary Team (MDT) input.

Medicines

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

- The service had in house pharmacy facilities Monday to Friday with a half day on Saturday. The pharmacist carried out daily stock checks, removed unwanted medication and reviewed medicine charts. Senior staff told us that they liaised with the pharmacist and conducted audits of any medicines in stock to ensure any unused items were returned and stock levels did not become too high. Staff were able to contact the pharmacist to order stock when needed.
- Medicines were stored neatly in a locked cupboard. We saw robust checking of medicines, including dates and removal and entry from the cupboard. On the treatment suite, controlled drugs (CDs) were stored in locked

cupboards, which a registered nurse held the keys for and which were checked twice a day. Two qualified nurses checked drug stock daily and a spot check of the register confirmed levels were correct.

- Medicine fridge temperatures were monitored daily. Appropriate actions were taken when these were out of normal range.
- Medicines were prescribed on the service electronic service by pharmacists and other clinical staff. The medicines were checked by the pharmacist two to three days prior to the patient attending for chemotherapy. The chemotherapy was prepared on site in the aseptic laboratory by the pharmacy team – this was rechecked by the pharmacist. The online prescriptions were transcribed to an electronic workflow system by pharmacy technicians and then double checked to minimise errors. Between November 2018 and February 2019 there were six medication errors recorded as incidents.
- The service used an electronic system to reduce errors. The system did this by employing a computer-based bar-coding system to eliminate most paperwork and transcription and increase precision in preparation of chemotherapy. The adoption of this system resulted in turnaround time of chemotherapy preparation being reduced from 45 minutes to 22 minutes.
- The aseptic laboratory consisted of three stages of decontamination with three adjacent rooms connected via hatches where medicines were passed from one room to the next. When dealing with medicine preparation, pharmacy technicians wore full personal protective equipment.
- The service ensured that Systemic Anti-Cancer Therapy (SACT) was not given via the wrong route. They did this by maintaining a rigorous training programme to ensure appropriate safety checks at all stages before the chemo was delivered. Pharmacists completed the SACT clinical verification training. In the 12 months prior to our inspection there were zero incidences of SACT being given via the wrong route.
- Since 2017, the electronic prescribing system flagged a scope alert when a practitioner records treatment outside an agreed protocol. This was then escalated to the medical advisory committee who would immediately discuss with the consultant. In the 12 months prior to our inspection, there had been no cases of a practitioner treating outside of agreed protocol.



Medical care (including older people's care)

- We saw pharmacists clinically verified each cycle of SACT to ensure that patients were being treated with appropriate evidence based SACT regimen. During the prescription verification stage, the pharmacist reviewed and recommended appropriate dose adjustments. This ensured that toxicities were minimised. Each patient was visited by a pharmacist on every visit to tailor their supportive therapy in line with patients individual side effect profile.
- Pharmacists at the service carried out medicine's reconciliation with all patient medicines. Medicines reconciliation is the process of identifying an accurate list of a person's medicines and recognising any discrepancies and documenting changes. This is to ensure that new medicines are prescribed with a full understanding of current medications. The service aimed to have medicines reconciliation completed on the day of treatment for 80% of patients. An audit carried out in one quarter (Q4) of 2018 found that 87% of patients had their medicines reconciliation carried out on admission or no more than two weeks prior to admission. For the remaining 13% of patients, their drug history was reconciled more than two weeks prior to attending the treatment suite.

Incidents

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

- An incident reporting procedure was in place and staff reported incidents via an electronic reporting system. Staff knew how to report an incident and informed us that they received immediate feedback from any incidents reported because they were a small team. This information was also fed into staff meetings where action plans were also discussed.
- Staff across the inpatient wards were aware of how to report and record safety incidents and near misses. All staff we spoke with were familiar with the electronic reporting system and how to navigate this. Staff that we spoke with said they were encouraged to report incidents. They were able to give examples of when they had used the system to report appropriate incidents.

The lead nurse had oversight of all incidents and these were discussed in weekly governance meetings. The learning from incidents was then feedback to staff each morning.

- Between January 2018 and December 2018 there were 52 clinical incidents reported and 12 non-clinical incidents reported. Of these, the service reported no incidents as 'severe' or 'death'. There were no trends in incidents.
- There were no serious incidents (SIs) reported across the service between January 2018 and December 2018. Nurses and consultants informed us that SIs were subject to a full root cause analysis (RCA) investigation with action plans developed too.
- There were no "never events" reported within the service in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Feedback and learning points from incidents were shared with staff via team meetings and the service intranet. Staff nurses informed us the clinical practice facilitator provided additional training in areas where there had been incidents.
- 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. Staff at all levels were aware of the expectation of openness when care and treatment did not go according to plan.
- Mortality and Morbidity (M&Ms) were held monthly with best practice letters being produced by a consultant after each meeting. This process ensured there was a formal record of any recommendations or findings associated with the mortality review to support the governance framework. We saw the minutes from three separate M&M's and found that they were thorough, included lessons learnt and mirrored best practice.

Safety Thermometer (or equivalent)

The service used monitoring results well to improve safety. Staff collected safety information.



Medical care (including older people's care)

- The hospital was not required to use the safety thermometer as it was a private healthcare provider. The service did, however monitor falls. In April 2019, there were no falls.

Are medical care (including older people's care) effective?

Good



This is the first time we rated effectiveness for this service. We rated it as **good**.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

- The service maintained an audit calendar for the year which detailed which audits would be carried out, the frequency of audits and the sample size. This audit calendar would also differentiate between audits carried out by the medical team and those carried out by the nursing team.
- We saw National Institute of health and Care Excellence (NICE) guidance implemented, for example:
 - NICE guidance CG51: Neutropenic sepsis: prevention and management in people with cancer (“Healthcare professionals and staff who come into contact with patients having anticancer treatment should be provided with training on neutropenic sepsis”).
- Policies and procedures referenced NICE guidance and other best practice and were stored on the service intranet for staff access. Chemotherapy protocols were prescribed on the service prescribing system for individual patients using NICE guidance and established cancer treatment pathways by experienced oncology clinicians. Any new protocols were reviewed by the medical advisory committee (MAC)
- The service had Protocol Management Policy in place for request, approval and validation of chemotherapy regimens. Once the request was made by a clinician, the protocol management team categorised the chemotherapy as a standard protocol (level 1 evidence) or off protocol (less than level 1 evidence) based on the framework. This was then reviewed by three clinicians who specialised in said tumour category and recommendation to proceed is made.
- The protocol management policy defines the levels of evidence which are taken from National Comprehensive Cancer Network and from the Oxford Centre Evidence-based Medicine.

Nutrition and hydration

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

- All patients attending for treatment were screened using the Malnutrition Universal Screening Tool (MUST) on the service electronic system. The dietetic department audited completion of the MUST quarterly and shared results with staff on the treatment suite. There was a dedicated nutrition champion that linked with the dietetic team.
- Patients had good access to a range of different food and drinks. Patients we spoke to on the day of inspection were complimentary about the food.
- The dietetics service was available to all patients and produced recipe cards for patients to encourage them to cook and eat healthy meals that would be palatable during their chemotherapy treatments.
- The service reviewed the nutritional management and outcomes of patients with diagnosis of pancreatic cancer. The aim was to improve treatment experience and quality of life by developing a standard and dietetic pathway for all new diagnoses of pancreatic cancer. The provider carried out audits into the dietetic management of pancreatic patients and found that all patients (14) were found to be meeting the gold standard for Pancreatic Enzyme Replacement Therapy (PERT) dosing following dietetic intervention.
- The service informed us that most of the outpatient function was to assist patients with symptom management, namely, nausea and vomiting. The service made use of both the dietetic team and pharmacological support to assist patients with symptom management.

Pain relief

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



Medical care (including older people's care)

- Recognised pain assessment tools were in use across the service. Nurses and consultants routinely asked patients about pain and patients told us their pain had been managed appropriately. The notes we reviewed showed that patients had been given necessary pain relief.
- At each treatment assessment, patients were assessed on pain symptoms. A pain score was then captured on the electronic system and medical notes were updated accordingly. If a patient arrived with acute pain, a nurse and RMO assessment would take place and pain relief would be administered as quickly as possible.
- Complementary therapies such as reflexology were also available to patients to help manage symptoms. Patients that we spoke with were generally satisfied that their pain was well controlled.

Patient outcomes

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

- The service benchmarked against other LOC facilities under the provider umbrella. The provider collected, monitored and analysed data in the following ways:
 - Mortality within 30 days of SACT
 - Dose intensity
 - Outcome of Individual Protocol use
 - Ongoing monitoring of patient weights, percentage weight loss and weight gained.
- The results included inpatients at provider facilities. All audits were discussed at the monthly Audit & Effectiveness committee.
- The outcomes of individual protocol use showed that outcomes for patients were improved in cases where patients were able to continue with less than Level 1 evidence treatment.
- The service provider performed an audit of door to needle times in cases of suspected neutropenic sepsis. This was a retrospective audit carried out in March 2019 and included patients from LOC @ Chelsea. The audit found that 94.4% (34) of patients with suspected neutropenic sepsis received antibiotics within one hour from arrival to a LOC facility and 5.5% (2) patients received antibiotics outside of the hour. This was out of a total of 230 patients. Of all those patients, 78% were either admitted to an HCA (provider) in-patient facility or

transferred via a blue light ambulance to a local NHS hospital. Most of these patients were receiving SACT for disease control and all continued with their planned treatment following the event.

- The service provider also conducted an audit into mortality within 30 days of SACT. An audit of 122 patients found that 13.9% (17) died within 30 days of SACT.
- Patients were provided with information about suitable clinical trials at the time the decision is made to treat. All suitable LOC @ Chelsea patients had access to clinical trials and were provided with information as part of their treatment. We saw three MDT minutes and found that all patients were considered for at least one trial.

Competent staff

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

- The service informed us that it offered protected time each month to all members of staff on the first Monday of every month where no patients were scheduled. Sessions were open to both clinical and non-clinical staff across LOC sites and LOC @ Chelsea staff had access to these sessions.
- In 2017, UK Oncology Nursing Society (UKONS) produced a National Systemic Anti-Cancer Therapy (SACT) Competency Passport to ensure that all oncology nurses were trained in the same competencies. The service provided training in line with the SACT passport as well as additional competency training that took account of the additional service lines provided. This enabled nurses at the service to provide a wide range of SACT for various cancer types. The service clinical practice facilitator had begun the process of training staff members on the SACT passport with the aim of having all staff trained.
- Nursing revalidation is a process by which registered nurses are required to demonstrate on a regular basis that they are up to date and fit to practice. The service had helped nursing staff through this process by offering guidance and support.
- Arrangements were in place to ensure those staff working under practising privileges had appropriate professional indemnity insurance. Treatment volumes were audited quarterly through FECC (Facility, Ethics



Medical care (including older people's care)

and Compliance Committee). If a consultant was inactive for 90 days on the electronic patient record system, they were identified as 'INACTIVE' and were unable to access systems without another induction.

- Evidence was provided to indicate that the process of granting and removing practising privileges, including scope of practice, worked in a satisfactory manner, and that reviews of consultant practice took place as and when necessary. Consultant personnel records were recorded electronically and managed by the provider's centralised credential team. We looked at four electronic consultant files which demonstrated the hospital had followed their policies and all relevant documentation was up to date and reviewed annually.
- HCA UK is the designated body for six of the 75 Consultants with practising privileges. For all other consultants, the responsible officer (RO) was provided by the NHS or another independent provider. Consultants appraised through their NHS trust or other independent hospital had to provide a copy of this to LOC @ Chelsea each year. Scope of practice was also reviewed and monitored, with an annual check as part of the practising privileges audit. Medical staff were required to be trained and signed off before using any specialised medical equipment before they could use these with patients.
- All staff we spoke to, including nurses, administration, health care assistants, house keeper and cleaner confirmed they had had an appraisal within the last 12 months including a personal development plan.
- There were arrangements for supporting new staff at the hospital, including an induction and supernumerary period during which clinical competencies were assessed. We reviewed the corporate education, training and development policy and found it included a segment on the service educational training plan for new starters. We spoke with staff nurses who had started at the service recently and they informed us that they had a rigorous induction system that saw them have a buddy for the first few shifts until they were confident enough to work on their own. There was an induction for consultants who were granted practising privileges and evidence of their mandatory training, which may have been completed elsewhere, was obtained and recorded electronically.

- The clinical nurse specialist (CNS) team provided teaching and training to staff on the different cancer type and the specific needs of the patients in relation to their diagnosis.

Multidisciplinary working

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

- Staff told us that they enjoyed working with their colleagues and were complimentary about the support they received from one another. We observed good working relationships between all grades of staff and all professional disciplines.
- Multidisciplinary team (MDT) meetings took place regularly throughout the month. Consultants were able to present patient cases at MDT for advice. We attended an MDT that was well staffed with consultants, clinical nurse specialists, interventional radiologists and allied health staff.
- The service also used an electronic MDT to involve other professionals in clinical discussions which meant there was no delay in patient treatment. The eMDT enabled patients to receive review from consultants around the world whilst providing clinicians the clinical information necessary to make the best decision for the patients.
- The clinical nurse specialist (CNS) team were the key professionals accessible throughout the MDT process and helped to ensure seamless, integrated multidisciplinary care.
- We received evidence that the staff worked closely together with the consultant base e.g. pharmacy staff worked with consultants to review the provisions of pharmacy and SACT and presented results at the provider's SACT board.

Seven-day services

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

- The service was open 8am to 8pm Monday to Friday and 9am to 5pm on a Saturday. The service was not open on Sunday.
- During opening hours, the service had access to physiotherapy, occupational therapy and therapeutic services.



Medical care (including older people's care)

- Diagnostic imaging was available during opening hours. Images carried out included Positron emission tomography-computer tomography (PET CT), dynamic Positron emission tomography-computer tomography (dPET CT) and Diffraction Contrast Tomography (DCT).
- Patients had access to support from staff at any time. They were provided with a card that had an out of hours number on it. This number directed patients to the out of hours triage line. We spoke with one patient who had used this number and said that it was “Excellent, really set my mind at ease when I had symptoms”.
- LOC operated an out of hours telephone triage service using the UKONS Telephone Triage Tool for assessment and guidance. The 24-hour triage service allowed patients and family members to contact a trained nurse team member for advice on symptoms related to toxicity, side effects from treatment, medication advice and emotional support. The service also co-ordinated an admission to an inpatient facility with the patient and consultant's consent if required. If a patient was triaged as being acutely unwell, the triage line would ask the patient to call an ambulance, ensure safe handover and follow up to ensure advice or treatment was followed. The 24 hour line provided access to specialist advice by a specialist nurse and consultant oncologist/team.
- All consultants were available for their patients 24/7 and contactable via telephone or email. The service had an on-call rota of oncology consultants as a back up to the triage nurse team who were available to support and advise in the situation if the primary consultant is not contactable. In the event of planned absence, consultants arranged appropriate consultant cover, details of which were shared by their secretaries. The consultant on call and consultant absence cover arrangements were available to all teams and updated daily by the treatment suite coordinators.

Health promotion

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

- The service offered a health screening package referred to as reAssure. This health screen came in four different tailored packages and provided patients with a report of main health risks and guidance to minimise risks and

improve well-being. Clinical decisions were documented in patient records including referrals to supportive therapies and other services such as smoking cessation.

- Patients were provided with materials they could read that would outline the impact of the systemic therapy they were receiving.
- The service offered a ‘Living Well’ programme which included: emotional wellbeing workshops, physical activity and strength workshops, nutritional wellbeing and mindfulness classes. Each patient was guided through the programme calendar and given advice as to which even would best suit their needs.
- Complementary therapies included massage, reiki, reflexology and aromatherapy. Patients were informed that this was provided to promote relaxation and reduce stress. Complementary therapists ran workshops as part of the living well programme. Oncology physiotherapy was offered for all tumour groups and this included post-surgical follow up for a range of strengthening and release exercise. We saw the therapist also assisting with post treatment symptoms such as cancer related fatigue and rehabilitation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

- We saw there were systems to obtain written and verbal consent from patients before carrying out procedures and treatments. All patients we spoke with informed us that the risks of treatment and alternatives were discussed prior to starting treatment.
- Staff we spoke with gave clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA).
- All staff (100%) were trained on MCA and Deprivation of Liberty Safeguards (DOLS).
- A consent audit, carried out in April 2019, showed 91.7% compliance with agreed documentation standards. The audit found that not all documentation was being filled out consistently, but that patient consent was being sought in 100% of cases. Staff were reminded of the importance of filling out documentation correctly as a result.



Medical care (including older people's care)

- The hospital did not accept patients for admission that were deemed to lack capacity regarding treatment decisions. Staff gave clear explanations about their responsibility in ensuring patients understood the treatment they had consented for and described the process they would follow if they had concerns.
- Since the hospital had opened, the Care Quality Commission (CQC) received no notifications of Deprivation of Liberty applications from the service.

Are medical care (including older people's care) caring?

Outstanding



This is the first time we rated caring for this service. We rated it as **outstanding**.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and patients felt as though their individual needs were taken into consideration.

- The service provided each new patient with a holistic needs assessment (HNA) which assessed any additional physical and mental health needs. At this assessment the cultural, social and religious needs of the patient was taken into consideration. The service emphasised the importance of patients emotional and social needs. They set up patient groups and support networks and signposted patients to them accordingly.
- All patients without exception we spoke with were consistently positive about the care they received, praising the staff as being a "Family". We observed interactions between staff and patients prior to, during and following chemotherapy treatments. Interactions throughout the clinical process were seen to be positive, caring and patient led. Staff had a caring, compassionate and sensitive manner. One patient informed us that "having treatment here is my happy place, they make me feel very safe". Patients informed us that staff went the extra mile for them and sat with them during treatment. One patient that we spoke with informed us that she came to the service specifically because she heard the care was "excellent" and that it "did not disappoint".

- During inspection we noted that all patients on the treatment suite were cared for in individual bays. There were curtains that could be pulled round the bays for additional privacy and patients informed us that they had adequate privacy.
- All patients spoke highly of the service and care provided but some did mention that it was often hard to know what grade staff were due to the ambiguity in uniforms. Patients were aware of who was providing them with treatment for their time at the clinic but could not understand staff grade based on uniform.
- The 2018 LOC patient experience survey captured patient feedback on the quality of LOC staff and services. 97.22% of patients rated an excellent-good service received from nursing staff and 94.44% of patients rated an excellent-good service received by consultants. The response rate was 59%.

Emotional support

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

- Staff were aware of the importance of providing emotional support to both patients and their families. We observed highly sensitive interactions between staff and patients. We saw patients and staff embracing. When we asked patients about this they informed us that "The service feels more like a family than anything else. I've never wanted for anything". All patients we spoke to felt as though they were being fully supported throughout their care.
- This support also extended to care during the last days of life. Staff received training in Care in the Last Days of Life from consultants and clinical nurse specialists (CNS'). This training included study days on symptom management as well as how to have conversations about the end of life.
- The service did have on site psychological support if needed. Nursing staff and clinical nurse specialists could refer patients to this service if needed. The service also ran emotional wellbeing workshops and signposted patients where appropriate. We saw some feedback from the sessions and all patients responded



Medical care (including older people's care)

positively to the session. The session was due to open up to family members of patients too. One patient said “it was good to listen to other participants thoughts, experiences and issues”.

- The CNS' provided a personalised service for each patient. The CNS' were present during clinics with consultants throughout the patient journey. CNS's assisted patients with a variety of things relevant to care they were receiving e.g. receiving complex care in the community. The CNS team were key to ensuring people had a positive experience of care.
- After running a patient survey the service recognised the need for a patient ambassador group. The service launched this group as a way for current and former patients to attend and discuss ideas to make the service better. Patients could voice their opinion of the service and we saw examples of the service making changes accordingly. At these groups, patients were able to discuss the support they needed and staff always accommodated these requests.
- The provider ran a memorial remembrance event for all of its inpatients and outpatients family members who had been affected by bereavement.

Understanding and involvement of patients and those close to them

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

- We saw that patients' individual preferences were always taken into consideration. When receiving treatment, patients were allocated their preferred treatment bay and were always offered the opportunity to lie down during treatment if they were prone to nausea.
- Staff informed us that ensuring patients were fully involved in their care plan was of the utmost importance. Staff came in early and left late to ensure patients were treated at times that suited them. One patient told us that they preferred to attend after work and this was always accommodated.
- Through discussions with the patient group the service recognised that there was a need for peer support for myeloma patients as private cancer patients do not

always have access to national or regional support groups. A group was set up to support this need. Patient feedback was overwhelmingly positive about the support group and the group was also open to relatives.

- Patients told us they felt fully involved in planning their care, and in making choices and informed decisions about their future treatment. They felt that doctors explained things in a language they could understand and gave them enough information about different treatment options. All patients felt able to ask questions of those caring for them and felt listened to by their doctors and nurses. All patients we spoke with felt able to ask questions of those caring for them. One patient informed us that, “My consultant is brilliant, any questions I have, I know I can ask”.
- All patients we spoke with said that they were provided with the out of hours triage number if they had any concerns whilst the service was not open. Patients informed us that they were provided with adequate information throughout their treatment plan. If in doubt, patients could contact their consultant directly and discuss treatment plans or test results.
- The service provided information and support with payment of fees. All patients we spoke with informed us that they were aware of the cost of treatment prior to starting. In the year prior to our inspection there were zero NHS funded patients treated at the service.

Are medical care (including older people's care) responsive?



This is the first time we rated responsiveness for this service. We rated it as **outstanding**.

Service delivery to meet the needs of the patient base

The service planned and provided services in a way that met the needs of the patients it provided services to.

- The service had been adapted to meet the needs of their patient population. The service was newly opened and had been specifically designed with the needs of



Medical care (including older people's care)

oncology patients in mind. For example, the patient bays had high back chairs or beds depending on the patient. Some patients felt nauseous whilst receiving chemotherapy and so preferred to be laid down.

- Facilities and premises were appropriate for the services being delivered. The service building was purpose built. The treatment suite contained 15 bays, two of which were private. Some of the bays contained beds instead of chairs for patients who preferred to lie down whilst receiving treatment.
- Whilst receiving chemotherapy, patients were able to make use of scalp cooling machines. Scalp cooling can sometimes reduce or prevent hair loss associated with chemotherapy treatment. The staff at the service were specially trained in the use of the machines and were able to assist patients as well as train them in how to effectively use the machines.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences.

- The service had wide corridors, large bays and WC facilities to accommodate patients who were wheelchair bound.
- We saw that food available catered for those with different nutritional requirements, including those with food allergies, halal, kosher, vegetarian and vegan requirements. Patients we spoke to during inspection were positive about the range of food available to them.
- The service had a dementia champion who was able to provide support and guidance to both staff and patients on managing hidden disabilities. The champion had a toolkit which included all relevant documentation.
- Interpreter services could be accessed if required. There was an onsite Arabic interpreter to cater for patients from the Middle East, and access to an interpreting service for other languages.
- The trust had a psycho-oncology service where specialised care was provided for patients experiencing emotional difficulties or mental health problems. The service was provided by consultants, a counsellor, psychotherapist and specialist nurses. Patients could self-refer for psychology treatment whilst at the service. But patients could also be referred during the patient and integrated care meeting, held weekly. This meeting discussed all new patients and which ones might benefit from psychological support.

- Hair and image consultations were available for all patients who attended the service. The service had long established links with wig makers and specialist makeup artists. These services also provided workshops to both men and women.
- The service provided training to patients to be able to self-administer certain drugs. This provided patients who lived far away from the service to not have to visit so frequently.
- Patients could also self-refer for homeopathy and acupuncture as part of managing the symptoms of chemotherapy.

Access and flow

People could access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with service targets.

- Patients could contact the service via telephone to enquire about treatment both within and out of opening hours. Patients could go directly to a consultant who would then assess the patient's fitness for treatment. The service provided patients with pre-treatment consultations to identify any risks, allergies, dietary requirements and other general patient needs. This information was then uploaded to the electronic patient record and was used to plan each patient's experience.
- The service audited the time from decision to treat to treatment commencement and found that it was always within one week. This was within the service compliance target.
- There was a dedicated nurse daytime triage service that managed the triage in the day so that nurses on the treatment suite were able to provide dedicated therapy.
- Waiting times were recorded for all patients attending consultations at the service. For the month of June 2019, 52% of patients were seen within 5 minutes of arrival and 76% of patients were seen within 15 minutes of arrival. An audit carried out in 2018 (Q4) found that it took on average 16.8 minutes to dispense a manufactured SACT from the aseptic unit to the treatment suite. This same audit found that 100% of patients received their SACT within 60 minutes of arrival.



Medical care (including older people's care)

- The service audited to take away (TTA) turnaround time. TTA's are medications provided to the patient on discharge. The audit found that 79% of patients were given their TTAs before their discharge. This met the service key performance indicator.

Learning from complaints and concerns

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

- Patients and relatives had several ways of making a complaint. Complaints could either be raised verbally by speaking to the most senior member of staff on duty that day, or service users could make a complaint in writing or over the phone to the service manager.
- Investigations were documented electronically, and the chief nursing officer had overall responsibility for signing off complaints. A written acknowledgement to the complainant was sent within three working days of receipt of the complaint, unless a full investigation outcome could be provided within five working days. If they were unable to provide a full response within five working days, they would respond within 20 working days. If a response could not be provided within 20 working days, the complainant would be informed in writing for each 20-day period until a written response was provided. The hospital subscribed to the Independent Sector Complaints Adjudication Service (ISCAS) to resolve complaints independently, should the complainant feel their complaint had not been resolved at local level.
- Over the course of the reporting period the service received two formal complaints which had been handled in within the policy timeframe. There was no common theme amongst the complaints. Learning from complaints was shared with staff as often as they came up.

Are medical care (including older people's care) well-led?

Good



This is the first time we rated leadership for this service. We rated it as **good**.

Leadership

Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

- The service notified the CQC of an extended absence of the Chief Executive Officer (CEO), who is the registered manager. There was an interim CEO in post at the time of our inspection. The interim CEO managed the running of the service overall. The service employed a chief nursing officer who oversaw the nursing staff and pharmacy team.
- During our inspection, we noticed senior staff were visible on the treatment suite and knew staff of all levels. Nursing staff of all levels confirmed that they were approachable and easy to talk to. Staff informed us that they were made aware of senior management changes in advance and regularly received updates from the senior management team via the intranet and over email.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

- The provider vision was to “Be internationally recognised for excellence in cancer treatment by providing a unique standard of care that keeps the patient as the focal point in everything we do and inspires world-leading clinicians to work with us”.
- The organisation’s values, mission and vision were documented in the strategic plan which supported the strategic objectives. Whilst staff were proud to be part of the LOC team, they were not all aware of the vision and strategy of the service.

Culture

Staff felt respected, supported and valued. The service had an open culture where patients, their families and staff could raise concerns without fear.

- We saw good team working amongst staff of all levels. The medical team worked well together, with consultants being available for RMOs to discuss patients and to give advice. An RMO we spoke with informed us that ‘consultants are always on hand should I need any support’.



Medical care (including older people's care)

- Staff informed us that they were proud to work in their roles and liked the 'Big family' nature of the service. Both newer members of staff and older staff members alike were proud to work at the service.
- Staff we spoke to on the treatment suite told us they felt supported, respected and valued within the teams they worked in. Staff told us they were happy working at the service and felt they contributed to creating a positive work environment.
- Staff felt confident raising concerns to managers and appropriate action would be taken. Staff felt there was an honest and open culture where incident reporting was promoted. Staff were aware of duty of candour and were confident reporting incidents.

Governance

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

- The Health & Safety Committee, Patient Ambassador Group, Medicine's Management Committee and Learning from Incidents group met on a quarterly basis. All these groups fed into the monthly clinical governance committee which was chaired by the medical governance lead. The head of department meeting and the department team meetings fed into the clinical governance committee. All these governance meetings fed into the quarterly Medical Advisory Committee (MAC) meetings.
- The Medical Advisory Committee (MAC) advised on matters such as the granting of practising privileges, scope of consultant practice, patient outcomes, clinical standards and implementing new and emerging professional guidance. The MAC ensured there was a process for overseeing and verifying doctor revalidation, continuing practice development and reviewing practicing privileges.
- The service conducted audits that were reported to different governance groups. For example, an audit on all patients who received a SACT regimen with less than level one evidence. This audit looked at patient outcomes in terms of disease response, toxicities, time

to progression and mortality within 30 days of SACT. This audit was reported to the Systemic Anti-Cancer Therapy and Pharmacy Board, MAC and to the Audit and Effectiveness Committee.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

- We saw the hospital risk register, which referenced ongoing risks. These were graded with level of risk, relevant and reviewed regularly, with appropriate actions taken to mitigate against them. Staff were able to tell us about current risks on the register. At the time of our inspection the service had two open risks on the risk register. The risks were not assigned to an individual. They did, however contain a review by date. It was not clear who had oversight of the risk register and the individual risks on it. After the inspection, the service provided another copy of the risk register with the names of the assigned individuals for follow up, unredacted.
- An annual audit program ensured performance was monitored and managed consistently. Nursing staff participated in local audits, with the resulting information shared amongst staff to promote improvement. We saw appropriate action taken from internal audit results such as additional learning being put in place after a poor audit result in accurately filling out patient records.
- The service had service level agreements (SLAs) with partner provider facilities. The provider had an SLA management process, which included governance and yearly review.
- The provider improved access to participation in clinical trials for cancer patients. These patients were monitored closely in line with outcomes.

Information Management

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

- Staff could find patient information when they needed it. A clinical coordinator reviewed all patient records for



Medical care (including older people's care)

the patients attending the following day. Following on from this, a daily communication was sent to all staff highlighting any risks, concerns and specific patient requests.

- The service had a bespoke IT system that was connected to the corporate provider. This ensured that patients treated at any corporate facility were able to have their records checked whilst at the service. Patient information systems were password protected and trained staff had access to them. There were computer terminals at nursing and medical stations.
- All staff had access to their work email, where they received organisational information on a regular basis, including clinical updates and changes to policy and procedures.
- Information governance training was part of the annual mandatory training requirement for all staff working at the service. At the time of our inspection, 100% of staff were trained in information governance.

Engagement

Leaders and staff actively and openly engaged with patients, staff to plan and manage services.

- Emotional wellbeing workshops were available offering information and support highlighting common emotional challenges because of a cancer diagnosis. This allowed patients a chance to access peer to peer support and encouraged the development of coping strategies.
- The Patient Ambassador Group (PAG) was set up to give patients a platform to voice questions and ideas for service performance. PAG met several times a year to provide feedback on the service. For example, the PAG inputted into the redesign of the patient medicines information leaflet.
- The service provided comment cards to patients and their families to gain feedback from the service user point of view. The service had made changes after receiving feedback, for example, patients were provided with higher tables in treatment bays after a family member suggested they were too low.
- The provider carried out a pancreatic patient/carer support day. The day was modelled on the Pancreatic Cancer UK (PCUK) group day and was planned in





collaboration with them. The objective of the day was to improve patient treatment experience and quality of life by developing a dietetic pathway for all patients newly diagnosed with pancreatic cancer.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

- The service took part in a programme to gain accreditation for being a champion for scalp cooling. The champion status includes providing guidance, information and training on scalp cooling and best practice. The service had both nurses and healthcare assistant champions in the clinical areas to ensure best practice was followed to achieve the best results for patients in minimising hair loss. The patients we spoke with who were using the machine spoke highly of it.
- The pharmacy team provided practical training to all couriers of cytotoxic drugs so that they understood what to do in the event of a spillage.
- The UK Oncology Nursing Society (UKONS) produced a National Systemic Anti-Cancer Therapy (SACT) Competency passport in September 2017. The service clinical practice facilitator (CPF) attended train the trainer training with the aim of rolling out the SACT passport at the service. The service recognised that it was carrying out a greater range of SACT therapies than was included on the SACT passport. After gap analysis, it was identified that additional competencies had to be added to the SACT passport to make it useful to staff. In the year of 2019, there would be seven theory days for staff to attend that would cover a wide range of SACT competencies.
- The provider inputted into an article that was featured in the American Society of Clinical Oncology Journal (ASCO). This article related to virtual metastatic breast MDT's and highlighted the importance of broader oncological input for these patients.
- The provider service was accredited by Caspe Healthcare Knowledge System (CHKS) for its processes and standards which met international best practice standards.
- The provider was accredited as "European Society for Medical Oncology (ESMO) Designated Centre for Integrated Oncology and Palliative Care".

Diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are diagnostic imaging services safe?

Good 

This is the first time we rated safe for this service. We rated it as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Staff received mandatory training on a rolling annual programme which was provided through a mix of classroom-based sessions and e-learning. Topics for imaging staff included: basic life support, moving and handling, infection control and sepsis, privacy and security, ethics and code of conduct, fire safety, health and safety, equality and diversity, mental capacity act and deprivation of liberty safeguards and Prevent training. Data provided showed mandatory training completion rates were 100% for all imaging staff. Radiographers had completed additional training for radiation regulations, risks and use of radiation.
- The lead radiographer had oversight over the mandatory training of all outpatient staff and sent reminders if necessary. Mandatory training completion was reviewed on a regular basis and we were told this would happen during appraisals. Staff told us they were given enough time to complete training modules during working hours.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies and used national guidance to do so.

- The service had current safeguarding policies and procedures. These were available for staff to refer to on the hospital's intranet. Staff were aware of their roles and responsibilities to safeguard people and knew how to raise matters of concern appropriately. There was a named safeguarding lead and staff were aware of them. Imaging staff completed safeguarding vulnerable adults and children level 2 training as mandatory training modules, data provided showed four of five staff members had completed this training.
- Staff understood how to protect patients from abuse. Staff were clear if children accompanied patients to appointments, the patient was asked to ensure they had someone to care for the children while they had their appointment. Alternatively, patients were offered another appointment. The service did not treat patients under the age of 18 years.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

- All clinical and waiting areas we visited were visibly clean and tidy. We saw completed cleaning checklists dating back three months for all imaging areas and bright 'I am clean' stickers on equipment with information about when it was last cleaned. Staff cleaned equipment at the start of each day and in-between patients using sanitising wipes for surfaces and equipment. Disposable curtains were dated when they were put up and were changed every six months.

Diagnostic imaging

- Personal protective equipment, such as gloves and aprons, were available to staff.
- There were enough hand wash basins and hand sanitisers available in all areas of the department. Posters with illustrated hand wash instructions were placed near each basin. We saw staff adhering to 'bare below the elbow' guidelines and being compliant with recommended hand hygiene practices. Monthly hand hygiene audit results showed 100% compliance rates for the department in January to May 2019.
- We saw completed daily cleaning logs for imaging areas for the previous three weeks. Monthly cleaning audits for the previous three months showed 100% compliance with maintaining a clean environment and clean medical equipment.
- There was a general waste management and handling policy available for staff as well as a waste management and handling policy for radioactive waste. There was a service level agreement with an external company to collect and dispose of waste.
- Waste was segregated in different colour coded waste bags or appropriate containers. The clinical areas contained domestic waste, clinical waste and radioactive waste bins. Waste was contained in clearly marked bins and the lids were closed when not in use. We saw that sharps bins in use were signed and dated and not overfilled. Results of quarterly sharps audits showed 100% compliance in 2018. Waste bins except for domestic waste were emptied by clinical staff. Waste awaiting collection was stored securely in a way that prevented unauthorised staff, patients and members of the public from accessing it.
- Staff said when treating patients who had a communicable infection such as diarrhoea, they would be booked for the last appointment of the day with deep cleaning carried out afterwards.
- There were four individual rooms for patients receiving radioactive injections for positron emission tomography (PET) CT scans. They were equipped each with a comfortable chair and entertainment tablet unit. There were two changing rooms as well as toilet facilities for patients undergoing PET CT scans. There was a separate changing area for patients booked for conventional CT scans.
- Staff prepared injections of radioactive tracers in a designated treatment room, which was locked to prevent unauthorised access. Spill kits were stored in the treatment room. We saw storage cupboards looked organised and sufficiently stocked.
- There were working radiation warning lights outside the scanner room to warn people about potential radiation exposure and to prevent unauthorised access to radiation restricted areas. The warning lights were checked daily. Imaging staff performed daily and weekly quality assurance checks to equipment according to manufacturers' recommendations, including the scanner, dose calibrator and blood glucose meter. The service performed bi-annual audits of required quality assurance checks, for example PET calibrations, CT noise and uniformity or CT slice thickness. Results from July to December 2018 showed 100% compliance in all audit areas.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and repaired. An equipment quality assurance programme was undertaken by radiographers. We saw completed documentation of daily, weekly and monthly quality assurance checks for the PET/CT scanner. This was in accordance to IRMER requirements.
- Staff explained that the PET/CT scanner allowed a weight adjusted reduced radiation time and dose, thereby achieving a high resolution with a lower radiation dose. The CT had dose modulation capability to ensure the radiation dose was optimised to ensure patients did not receive any more radiation than needed.
- Staff were wearing personal dosimeter badges, used for monitoring cumulative radiation dose. Specialised personal protective equipment, such as lead aprons were available for staff. There was a hand and feet monitor with an electronic log available for staff. Staff used it at the end of their shift to check for radioactive contamination. Decontamination protocols were available if needed and staff were aware of them.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- All imaging areas we visited were well-lit and free from clutter.
- The entrance to the imaging department was swipe card protected and patients or visitors could enter only in company of an authorised member of staff.
- There was one computer tomography (CT) scanner in a clearly identifiable room with warning signs on the door.

Diagnostic imaging

- A resuscitation trolley with defibrillator was kept within the department. We saw records of completed daily checks and monthly audits.
- An external company performed environmental audits with radioactive substances regulation compliance. The last assessment took place in April 2018 and found no breaches or advised actions.
- The service had access to 24/7 picture archiving & communication system (PACS) support for troubleshooting needs. There were also super users who were able to help and fix day to day issues.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient.

- The service used questionnaires asking about previous investigations, allergies or any problems during previous imaging tests.
- Staff were aware of what action to take if a patient became unwell before, during or after a scan. All rooms were fitted with emergency bells to call for assistance. Staff we spoke with demonstrated they were familiar with escalation procedures, for example would contact the radiologist on site or the RMO. If indicated, staff would alert emergency ambulance services or arrange transport to a local Accident and Emergency department.
- If radiographers were concerned about an unexpected or urgent finding they would speak to the radiologist who would contact the referrer to discuss the result.
- Radiography staff screened patients who required contrast media for pre-existing conditions or allergies. Staff told us they could access latest blood results on the electronic patient record or perform a renal function test with handheld analyser. This was in keeping with the National Institute of Health Care Excellence (NICE) acute kidney injury guidelines and the Royal College of Radiologists standards for intravascular contrast agent administration. Contrast media are substances which increase the contrast of structures or fluids within the body used in certain types of radiological investigations.
- An anaphylaxis flow chart was on display in the department and an anaphylaxis kit was kept with the resuscitation trolley.
- The main legal requirements enforced by the Health and Safety Executive (HSE) are the Ionising Radiations Regulations 2017. The service was HSE certified for

deliberate administration of radioactive substances to people or animals for medical or veterinary diagnosis, treatment or research. In line with the regulations the imaging service had appointed radiation protection supervisors (RPS) whose role was to ensure staff followed the services standard operating procedures and adhered to the radiation protection procedures.

- Radiation protection meetings were held six monthly. We were shown minutes of previous meetings, which included action points assigned to individuals with deadlines. The purpose of these meetings was to monitor radiation safety throughout the hospital.
- The department had a full set of IRMER procedures and standard operating procedures as required under the Regulations. The Health and Safety Executive (HSE) regulate the Ionising Radiations Regulations 2017. We saw evidence of the service's HSE registration. Local rules were on display in accordance with procedures. All areas which utilised medical radiation in hospitals were required to have written and displayed local rules which set out a framework of work instructions for staff.
- To safeguard patients against experiencing the wrong investigations staff asked patients to confirm their identity by providing their full name, date of birth and first line of their address. This showed staff followed best practice and was in line with the legal requirements of Ionising Radiation (Medical Exposure) Regulations (IRMER).
- The service had designated radiation protection supervisors (RPS) available to provide guidance and support to staff. The service had a designated radiation protection advisor (RPA) to provide support and guidance. Staff knew their name and how to contact them.
- We saw local rules with the names of the radiation protection supervisors and radiation protection advisor. These rules summarise the key working instructions intended to restrict exposure in radiation areas. There was a signed list that all imaging staff had read the local rules.
- There was a process for the assessment of patients who may be pregnant. Posters were displayed in the changing rooms and toilets with a message to alert patients that if they suspected they were pregnant to speak with staff. Staff used a checklist to assess any potentially pregnant patient prior to any investigation and patients verbally confirmed, signed and dated they

Diagnostic imaging

were not pregnant. Staff told us they checked female patients' pregnancy status before any radiation exposure. If a patient was not sure and refused a pregnancy test, imaging tests were not performed.

- Basic life support training was part of mandatory training for imaging staff. Data showed 100% compliance.

Radiographer staffing

The service had radiographer staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

- The service was fully staffed with two molecular imaging radiographers and one nuclear medicine superintendent who was also the radiation protection supervisor. The imaging team was supported by a receptionist. There were always at least two radiographers on duty.
- There were no vacancies. The turnover rate was zero in the past 12 months. The sickness rate was 13.9% due to long term sickness of one member of staff. Their shifts were cross covered from staff of other LOC locations. The service did not use agency staff.
- There was one radiation protection supervisor working in the imaging department. The deputy molecular imaging manager would step in as their absence. We were shown evidence that their training was in date.

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

- A nuclear medicine consultant was present every day to supervise and report scans.
- Three nuclear medicine consultants reported the PET CT scans. Other radiologists with practising privileges reported regular CT scans.
- Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Most consultants with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts.

Records

Staff kept detailed records of patients' care and treatment.

- The department primarily used a paper referral system which was scanned onto the radiology imaging system. Several IT systems were used for maintaining patient records, uploading images and accessing images remotely. PACS was used for storing plain film images and the associated reports. Radiologists used voice recognition software to produce reports for PET CTs to CTs, which were saved electronically. Results and reports were available electronically to radiology staff and referrers. Radiologists could remotely access images if needed through a secure password protected system.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

For our detailed findings on medicines please see the Safe section in the medicine report

- Contrast media and other drugs used in the imaging department were stored securely in a locked cupboard. We saw three contrast bottles stored in a warming cabinet, all bottles were marked with dates to use within one month.
- The service used patient group directions (PGD) to allow radiographers to supply and administer contrast media or saline to patients without prescription. We saw PGD for contrast and saline injections which were signed by health care professionals involved. We saw signed authorisation documents for imaging staff to supply and administer specific medicines according to PGDs.
- Radiopharmaceuticals were checked for content and dose by two members of staff before administering to the patient. We saw staff delegation letters for administration of radioactive medicinal products.

Incidents

The service managed patient safety incidents well.

- From June 2018 to May 2019, the imaging service did not report any never events. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic

Diagnostic imaging

protective barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death.

- No serious incidents were reported for the imaging services in the same period. A serious incident requires investigation and can be identified as an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened. There had been no ionising radiation (medical exposure) regulations (IRMER) related incidents in 2018/19.
- There were four incidents reported by the imaging department between June 2018 and May 2019. All were categorised as no harm. The service reviewed incidents for themes and lessons to learn.
- Staff were aware of their roles and responsibilities for reporting safety incidents and near misses internally and externally. Staff said they received feedback from incidents they reported, they were also discussed at monthly department meetings. The imaging manager and superintendent attended monthly clinical governance meetings where service wide incidents were discussed. The service produced a monthly newsletter, which included learning from all incidents.

Are diagnostic imaging services effective?

We do not rate effective in diagnostic imaging

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

- The service took account of IRMER and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists (RCR), the College of Radiographers and other national bodies. This included all specialities within the diagnostics.
- We reviewed a range of clinical and operational policies and procedures. The policies reflected current national guidance. Radiographers followed standard operating procedures for scanning of individual areas or parts of the body. Staff had access to policies and procedures on the shared drive in a policy library, however staff we spoke with could not confidently and quickly access the policies or protocols we asked for.

Nutrition and hydration

Staff advised patients on food and drink restrictions in accordance with the investigation.

- Patients attending the imaging department were normally there for a short time and did not require food. Water and hot beverages were available in the waiting areas for patients and visitors.
- The referring doctors advised patients whether they had any food or drink restrictions at the time of referral. Imaging staff were available for additional advice or questions regarding food and drink intake around tests.

Pain relief

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

- Staff told us they ensured patients' comfort prior to completing investigations. For example, by repositioning the patient if possible or the use of pillows or foot rest.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

- The service had an annual audit programme, which included infection control audits, environmental audits and local audits, including dose reference levels, request forms, patient group directions audits, equipment, waiting times and turnaround times.
- Radiology dose reference levels were audited in the department and compared to national levels. Results for 2018 showed that diagnostic CT scans were all in compliance with national diagnostic reference levels.
- The service audited CT request forms to assess the completion of the forms by referrers and in addition to ascertain the 3-point identification (ID) check undertaken by radiography staff as recommended in IRMER guidelines. Results for October to December 2018 showed 100% compliance with 3-point ID checks and 100% in all other audit criteria except for 95% with radiographer confirmed protocol/exam required and initialled.
- Patient group directions were audited quarterly. Results for contrast imaging checklists from October to December 2018 showed 100% compliance for all 15 audit subjects, except for documented advice given to patient including side effects (50%).

Diagnostic imaging

- An audit of the PET CT service reviewed 100 request forms from February to April 2019, looking at indications on request cards and reports. Results showed that 86% were internal requests and most (95%) contained a clinical history but 10% did not have a clinical question. The audit showed good report quality with 90% reports free of grammar or typographical errors. Findings were shared in meetings and the voice recognition software was upgraded to further improve report quality.

Competent staff

The service made sure staff were competent for their roles. Staff who administered radiation were appropriately trained. Staff who were not formally trained in radiation administration were adequately supervised.

- All new staff attended an induction at a local and corporate level, before they could begin working. The service used a competency form for new starters containing radiology related aspects of work.
- There was learning pathway for each member of staff, which included radiology or nuclear imaging related training. Progress was checked during regular performance reviews and yearly appraisals. Staff we spoke with said they had participated in an appraisal in the previous 12 months. Data provided by the service showed 100% of staff had participated in an appraisal in 2018.
- The manager maintained a record of staff competencies assessment on modalities and equipment. All staff were senior radiographers who were skilled in most of the modalities offered by the service.
- We saw an up to date record of radiographers Health and Care Professions Council registration (HCPC). This was in line with the Society of Radiographers' recommendation that radiology service managers ensure all staff are appropriately registered
- Staff had access to a range of standard operating procedures for diagnostic CT scans. However, diagnostic CT scans were not performed daily and not all staff had the same experience in CT scans. Radiographers could rotate to other imaging departments of the same provider to enhance and maintain their competencies.
- There were quarterly education meetings for imaging staff where learning and updates were shared.
- The radiation protection advisor had delivered training to the radiation protection supervisor (RPS). We saw the appointment letter.

- All consultant radiologists working at the hospital had practising privileges which gave them the authority to undertake private practice within the hospital. The hospital practising privileges review process was annual and included a review of the consultant's scope of practice. This ensured the hospital had oversight of their ability to practice.
- All consultants requesting a PET CT scan were licensed to do so under the Medicines (Administration of Radioactive Substances) Amendment Regulations 1995 and 20016.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

- There were regular multidisciplinary team (MDT) meetings for different specialties to review patient cases. Nuclear imaging consultants attended regular MDTs, for example gastrointestinal or breast MDTs, which were organised at provider level. Each case was documented on a standardised MDT form, which included patient history, radiology findings, details of discussion and recommendations.

Seven-day services

The service operated over a Monday to Saturday period.

- The imaging service was open 8am to 8pm Monday to Friday and 9am to 5pm on Saturday.

Health promotion

Please see the medicine report for more information.

Consent and Mental Capacity Act

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

- Staff completed training on the Mental Capacity Act annually as part of their mandatory training modules. Although staff had received training on mental capacity they said it was unlikely they would see patients who lacked mental capacity issues in their service. However, they were aware of what to do if they had concerns about a patient and their ability to consent to the scan.

Diagnostic imaging

- There was a corporate consent policy and staff were aware of it and knew how to access it. Consent was obtained prior to the delivery of care and treatment. Radiographers obtained written consent from all patients before procedures. We saw examples of correctly completed consent forms during inspection.

Are diagnostic imaging services caring?

Good 

This is the first time we rated caring for this service. We rated it as **good**.

Compassionate care

Staff cared for patients with compassion.

- Staff demonstrated a kind and caring attitude to patients. This was evident from the interactions we witnessed on inspection and the feedback provided by patients. Staff said they took the time wherever possible to interact with patients and their relatives. We observed staff addressing patients and visitors in a polite and friendly manner and actively offering their assistance.
- The imaging department collected local patient feedback using a patient satisfaction questionnaire specific to their service. We saw these leaflets throughout the department for patients to pick up. Part of the questionnaire was to ask patients how likely they would recommend the hospital to friends and family.
- We saw compliments on display within one of the offices. One of the comments was: "Friendly and warm staff, highly professional, kind and caring".

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Staff supported patients through their investigations, ensuring they were well informed and knew what to expect. Staff told us how they provided reassurance and support for nervous and anxious patients, demonstrated a calm and confident manner to relax patients. Staff had enough time to answer questions and phobic patients were offered eye masks and could try to lie in the scanner beforehand to assess their level of anxiety.

- Patient feedback reflected this, one of the patient feedback comments was: "During what is a rather nerve wrenching experience, she [staff] made it as easy as possible".
- The provider offered a helpline for employees for support and advice.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- Staff took time to explain the booked procedure. They made sure patients understood the nature of the test and recommendations and instructions, for example to avoid close contact with young children after the PET scan.
- One of the patient feedback comments was: "[Staff] explained everything carefully and in detail. She was very gentle and sympathetic. She did a wonderful job at making me feel calm and relaxed. I found the CT scan very strange but [staff] explained what would happen so well".
- All patients received a CD of their images to forward on to their doctor who had made the referral.

Are diagnostic imaging services responsive?

Good 

This is the first time we rated responsive for this service. We rated it as **good**.

Service delivery to meet the needs of local people

The provider planned and provided services in a way that met the needs of local people.

- The imaging department performed PET CT and CT scans only. Patients requiring other tests were referred to one of the other locations nearby.
- The main waiting area was furnished to a high standard and provided enough comfortable seating. There was a range of free hot and cold beverages available, as well as newspapers and magazines to read. There was access to free WIFI for patients and visitors.

Diagnostic imaging

- The service had a front of house pathway and imaging staff collected all patients from the main waiting area after being informed of their arrival by reception staff. Wheelchairs were available if required.
- There were four injection rooms for PET CT scans. Patients undergoing PET CT had to wait for about one hour after injection of the radioactive tracer before the scan. One of the rooms was designed to accommodate a patient bed, the others had comfortable electric chairs and entertainment units.
- The clinic was in central London and was easily accessible by public transport. However, there was limited pay and display car parking outside the hospital.
- There were service level agreements with external providers for waste collection, cleaning, medical equipment and servicing.

Meeting people's individual needs

The service took account of patients' individual needs.

- Secretaries and staff would enquire if patients had special needs or required additional support when booking appointments. This allowed them to decide ahead of visits.
- The service took account of the accessible information standard by identifying and recording communication needs at the time of booking the appointment. The department offered hearing loops for patients with hearing impairment. The service would book an interpreter if required and had access to a telephone interpreting service.
- Staff told us they would come in earlier or stay late if a patient requested this, to accommodate their work or travel schedule, for example.
- Staff told us they had enough time as the patient needed to explain the procedure. Staff commented it was valuable to be able to spend time with patients to make sure they fully understood the procedure and thereby help reduce stress.
- Patients were offered to listen to music during the scan and patients could bring their own music. There were eye masks for claustrophobic patients and staff told us patients could try lying in the scanner before the actual scan to reduce anxiety.
- We saw patient information leaflets and radiation risk and benefit leaflets.

- Patients with mobility issues could enter the imaging area with a wheelchair. The waiting area was large enough to accommodate wheelchairs and patients with mobility issues.

Access and flow

People could access the service when they needed it.

- Local doctors and consultants in the clinic referred patients to the service. Patients could book appointments over the phone or in person and could choose their preferred date and time. Appointments were flexible to meet the needs of patients and they were available at short notice or on the same day.
- Local doctors and consultants referred patients to the service via paper referral forms, which were later scanned into the electronic system. Staff checked referrals for completeness and would contact the radiologist if they had any concerns.
- The service audited waiting times quarterly where 40 patients were randomly sampled. Results for January to March 2019 showed that 92.5% of patients were seen earlier or on time of their appointment, 7.5% were seen after appointment time due to the patient being late.
- Data provided for January 2018 to April 2019 showed that almost 1,100 scans were performed and about 11% of booked appointments had been cancelled in the same period. Data showed that the service had a low proportion of patients who did not attend for their appointment, approximately 3% over the last 12 months.
- All PET CT and CT scans were reviewed by a consultant and reported within one working day and this was six-monthly audited. Data for July to December 2018 showed that 99% of PET CT scans were reported on same day and 100% within 24 hours. For the same period, 60% of CT scans were reported on the same day and 100% were reported within 24 hours.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- Complaints were dealt with by staff in the imaging department to resolve issues locally and informally. If this was unsuccessful, staff would escalate concerns to one of the managers. We saw leaflets with information

Diagnostic imaging

how to make a complaint in the department. There was a corporate complaints policy. The comments noted by patients in the patient feedback forms were also acted upon if they contained a complaint.

- Investigations were documented electronically, and the chief nursing officer had overall responsibility for signing off complaints. A written acknowledgement to the complainant was sent within three working days of receipt of the complaint, unless a full investigation outcome could be provided within five working days. If they were unable to provide a full response within five working days, they would respond within 20 working days. If a response could not be provided within 20 working days, the complainant would be informed in writing for each 20-day period until a written response was provided. The hospital subscribed to the Independent Sector Complaints Adjudication Service (ISCAS) to resolve complaints independently, should the complainant feel their complaint had not been resolved at local level.
- The complaints log for May 2018 to April 2019 showed the imaging department received two complaints regarding delay and staff attitude. Staff had investigated each complaint and shared learning and actions.
- The deputy molecular imaging manager and the superintendent attended a weekly clinical governance meeting where complaints were discussed. Information was shared in departmental meetings.

service was managed with regards to the management of risks associated with radiation. Managers were aware of risks and challenges to sustainability and quality of the imaging service.

- Staff told us leaders had the skills and experience to appreciate the roles they completed and offered valuable support. Staff felt valued and said managers were visible, supportive and approachable with strong leadership skills.
- Staff were aware of the executive team and found them visible and approachable.

Vision and strategy

The provider had a vision for what it wanted to achieve and workable plans to turn it into action.

For our detailed findings on vision and strategy please see the relevant section in the medicine report.

- The imaging service did not formulate their own vision or strategy but were aligned with the provider wide vision to be internationally recognised for excellence in cancer treatment by providing a unique standard of care, keeping the patient as the focal point.
- Staff we spoke with were aware of the strategy for the diagnostic and imaging service and had been involved in its development

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- The imaging service was a small cohesive team. Staff we spoke with had a strong commitment to their role and were proud of the team working and quality of care, focusing on having a positive impact to both patient care and experience. Staff attended monthly team meetings and notes showed they were well attended.
- Staff expressed high job satisfaction and it was clear from talking to staff that there was a good working relationship between staff. There was a good sense of teamwork and people helped each other out. Staff felt supported in their work and said there were opportunities to develop their skills and competencies, which senior staff encouraged. Staff told us they felt valued and supported by colleagues and senior managers.

Are diagnostic imaging services well-led?

Good 

This is the first time we rated well-led for this service. We rated it as **good**.

Leadership

Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care.

- A Deputy molecular imaging manager led the service and reported to the provider wide head of imaging. The molecular imaging superintendent was running the service daily and functioned as the RPS. She described a good working relationship with the deputy molecular imaging manager and was confident in the way the

Diagnostic imaging

- Staff were aware of the duty of candour (DoC) regulation and evidenced through discussion the appropriate application of the duty when required. The DoC is a regulatory duty which 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.
- Staff received training in equality and diversity as part of their mandatory training modules and there was a corporate diversity and inclusion policy. Staff were aware of the policy and told us they would escalate any concerns and seek further guidance if necessary.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for clinical care to flourish.

For our detailed findings on hospital governance please see the relevant section in the medicine report.

- The PET CT service had a clear systematic governance process in line with the hospital governance framework to continually improve the quality of service provided to patients. Staff understood their roles and accountabilities.
- Staff regularly undertook internal quality audits to assist in driving improvement.
- Governance issues related to the imaging department were presented in clinical governance meetings, where complaints, compliments, learning, and complex cases or workflows were discussed.
- There were bi-weekly meetings with senior management of the different providers offering services within the same building. Incidents or any issues of interest for all services were discussed and information was shared.
- Discrepancy meetings took place six-monthly where findings not matching in subsequent surgery or different findings in scans were discussed as well as learning from errors.
- We saw minutes of the formal meetings of the provider wide radiation protection committee which took place bi-annually and were attended by the RPA, members of governance team, head of imaging and chief physicist, issues or updates around the PET CT scanner at LOC

Chelsea were discussed there. The RPA had undertaken an annual audit of the service in April 2019 and we saw the recommendations had been addressed to correct non-compliance issues.

- The service had a backup generator that was fully functional should there be any power outages.

Managing risks, issues and performance

The provider had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

For our detailed findings on managing risks, issues and performance please see the relevant section in the Medicine report.

- The service had clear processes and systems for identifying and mitigating risks. There was a risk assessment system locally with a process of escalation onto the corporate risk register. The risk register for the imaging department was reviewed monthly. We saw the departmental risk register, which contained description of risks, risk level, controls in place and progress notes. An example from the risk register was the risk of no radiopharmaceutical supply. We saw risk assessments were undertaken and covered all aspects of the service, staff, environment and equipment. Risks were discussed at departmental team meetings and governance meetings.
- The service undertook a range of radiation risk assessments. They addressed occupational safety as well as risks to people using the service and the public.
- The imaging department undertook regular audits as part of the regular audit programme to monitor quality of service and performance.
- According to data provided, 88% of LOC Chelsea staff had completed fire safety training as part of their mandatory training. We saw fire evacuation plans throughout the department and staff were aware of them. In addition, there were 14 trained fire marshals across the site and fire simulation training was carried out earlier this year.

Managing information

The provider collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Diagnostic imaging

- Staff used the hospital's computer systems to access hospital policies and resource material. Each member of staff had their personal login information to access the systems. There was enough information technology equipment for staff to work with across the service. During inspection, we saw staff logging off before leaving computers and we did not see unlocked computer screens. This prevented unauthorised access to data.
- Radiographers had access to patient's previous scans which enabled them to identify if patients have been subject to previous scanning which may still be appropriate for use. This removed the risk of patients receiving repeated short-term exposure.
- Information from scans was available to view remotely by radiologists which gave timely advice and interpretation of images to determine appropriate patient care. All patients received a copy of their images on an encrypted disk before discharge.
- Information governance training for staff was part of the mandatory training programme and data provided showed 100% compliance of imaging staff.
- Staff surveys were carried out through an external company; the hospital wide results for May 2019 showed a response rate of 52% and an engagement index of 54 for LOC Chelsea. This was comparable to LOC wide locations. An action plan was written in response to survey results, actions included for example, monthly staff forums.
- Departmental team meetings for all imaging staff were scheduled monthly. We saw meeting minutes with a structured agenda and action points arising from discussion. Staff discussed current issues and shared relevant information. Meeting minutes were emailed to staff and were available to read in a shared folder. The notes of the previous two meetings showed good attendance of team members. The notes demonstrated issues were communicated clearly and followed through. For example, risks and complaints were discussed and actions taken in response.
- The team used daily staff meetings in the morning to share information and updates.
- The hospital had an employee of the quarter award and any employee could be nominated.
- Staff told us about cards for birthdays and work anniversaries.
- There was a corporate helpline for employees to offer advice and support.

Engagement

The provider engaged well with patients and staff to plan and manage appropriate services.

For our detailed findings on engagement please see the relevant section in the medicine report.

- Patient views were actively sought within the imaging department with local patient feedback forms. We saw forms available for patients throughout the department. Data provided for 2019 showed a participation rate of 13% on average. Patient feedback was mostly positive, and comments included: 'The care and consideration for my treatment were outstanding'.
- The service used a modern scanner which enabled staff to use a weight adjusted reduced radiation time and dose, thereby achieving a high resolution with a lower radiation dose.

Learning, continuous improvement and innovation

The provider was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

Outstanding practice and areas for improvement

Outstanding practice

- The on-site phlebotomists, pharmacy and aseptic suite meant that the service offered a one-stop shop and patients rarely had to wait.
- Data provided showed that 100% of PET CT and CT scans were reported within 24 hours (July to December 2018).
- Staff worked especially hard to make the patient experience as pleasant as possible. Clinical Nurse Specialists recognised and responded to the holistic needs of their patients. Patients spoke very highly of the staff and stated that they went 'above and beyond'. Staff created support groups and signposted patients to those groups where necessary.
- Despite the outpatient nature of the service, the service provided a plethora of complementary therapies, from reflexology to massage to assist patients with symptom management.

Areas for improvement

Action the provider SHOULD take to improve

- The service should ensure that all risks on the risk register are assigned to a responsible individual.
- The service should consider making it clear what grade staff are by printing up posters with staff uniforms and grades.
- The service should ensure that all staff are aware of how to access key policies.