Loc @ The London Bridge Hospital Llp

LOC - Leaders in Oncology Care at London Bridge Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We rated it as outstanding because we found many examples of high quality, safe, innovative care:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse and worked with external agencies to do so, and managed safety well. The service controlled infection risk well. Staff thoroughly assessed risks to patients, acted on them and kept good care records. They managed medicines well and were consistently supported by the pharmacy team to do so. The service managed safety incidents well and learned lessons from them and fostered an open environment where incident reporting was encouraged.
- Staff provided excellent care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were contactable seven days a week.
- Staff went above and beyond to treat patients with compassion and kindness. The service was orientated towards respecting patients' privacy and dignity and providing personalised care. Staff took account of their individual needs and helped them understand their conditions. Patients and their families were provided emotional support through a variety of support services. Despite the outpatient nature of the service, patients and their families had access to a wide selection of complementary therapies such as massage, aromatherapy and reiki.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait for treatment.
- Leaders ran services well using reliable information systems and actively supported staff to develop their skills. They were forward thinking with a focus on continuous improvement and engaged staff in developing the service. Staff felt respected, supported and valued. They were focused on the individual needs of patients receiving care. Staff were clear about their roles and accountabilities and all felt able to suggest improvements. The service engaged well with patients to manage services and actively sought their views and ideas about how their experience could be enhanced. All staff were committed to improving services.

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 ☆	The main service carried out at this location was care for patients with cancer. This service was part of the wider oncology offering at London Bridge Hospital and was responsible for patients' outpatient appointment, chemotherapy treatment and PET CT scans. We rated this service as outstanding as they were outstanding in effective and caring and good in safe, responsive and well led.

Summary of findings

Contents

Summary of this inspection

Background to LOC - Leaders in Oncology Care at London Bridge Hospital

Leaders in Oncology Care at the London Bridge Hospital is operated by Loc @ The London Bridge Hospital Llp, which was overseen by the wider HCA Hospitals brand. The service opened in 2017 and is a private service in south London. In 2018 the PET CT service was added to the service offering. The service primarily serves communities in London but, accepts referrals from outside this area and overseas.

The service had a long-standing registered manager in post.

The service was registered to provide the following regulated activities:

- Treatment of disease disorder and injury
- Diagnostic and screening procedures
- Surgical procedures

Leaders in Oncology Care at London Bridge Hospital provides care for patients on cancer care pathways including consultation appointments, PET CT scans and chemotherapy. A PET CT scan is a combination of a PET (Positron Emission Tomography) scan and a CT scan. PET scans show how active cells are in different parts of the body, using radioactive injections and are combined with CT scans to show this mapped with patient anatomy. Other oncology treatments such as surgery or radiotherapy were completed by the wider London Bridge Hospital team. The service had no overnight beds.

We have not previously inspected this service.

The main service provided at this service was care for patients with cancer. We have reported the whole pathway in medical care. Where our findings are specific to diagnostic imaging, chemotherapy or outpatients we have made this clear. Where findings are true across all of Leaders in Oncology Care at London Bridge Hospital we have referred to this as “the service”.

How we carried out this inspection

The team that inspected the service comprised of one CQC inspector and a national professional advisor with experience in cancer care. The team was overseen by Nicola Wise, Head of Hospital Inspection.

The inspection was completed in one day, with follow up interviews with senior leaders from the service carried out after the on-site inspection.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

- The service had taken an innovative approach in helping staff to identify and respond to domestic violence, with a clear process in place to ensure those at risk were signposted to specialist services for immediate support.

Summary of this inspection

- The electronic prescribing system for chemotherapy ensured that treatment was not prescribed outside agreed protocols, with a flag on the system to ensure that any anomalies were investigated by senior team members. The pharmacy team were included in the patient pathway to review all patient medicines and offer direct advice to patients.
- In the last year, the service had been awarded the Macmillan Cancer Support MQEM award, being awarded a score of five (excellent). This award involved a combination of environmental assessments, a review of supporting documents as well as getting direct feedback from patients and users of the service.
- The PET CT service required all images to have two radiologists report on images to reduce the risk of interpretation bias.
- The service had produced a range of videos with patients and clinicians for other patients to learn about different aspects of treatment at the service. These were available on their own website and social media channels.
- 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 were 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. Patients and their families were provided with a selection of complimentary therapies free of charge such as massage, aromatherapy and reiki. People using the service were provided with access to various support groups co-hosted by Macmillan. This meant that the patient's holistic needs were being actively addressed.
- The provider introduced a pan cancer type molecular tumour board as part of their MDT meetings to discuss the results from commercially available tests on an individual patient's tumour genetic profile. This guides treatment plans for targeted SACT, either as first line treatment or on progression from other lines of treatment. This also gives an opportunity to access available clinical trials, either at local NHS institutions or via another site managed by the provider.

Our findings

Overview of ratings

Our ratings for this location are:

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

Outstanding

Medical care (Including older people's care)

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

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

Good

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Staff were given protected time to complete their mandatory training.

Clinicians who were employed in the NHS provided proof of training and course dates which could be transferred to this service. They received reminders when it was due to be updated so the service knew training was up to date.

Clinicians who were not employed in the NHS were required to complete all mandatory training with other staff. Clinicians were unable to pass their annual review if they had outstanding mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Almost all members of staff were 100% compliant with their training. At the time of inspection 96% of training was completed for the chemotherapy day unit and 100% completed for the PET CT scanning team. This was within the targets set by the service.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse and with the exception of one person all were up to date with adult training. All members of staff were up to date with child safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. All staff were clear about their responsibilities, including how to contact and how to make a referral, to protect patients and their families from harm or a risk of harm.

Throughout the service there were posters to remind staff how to make a safeguarding referral and who to make this to.

There were posters throughout the service, in different languages offering support for patients who may be suffering abuse. The service monitored their safeguarding notifications and identified a 300% increase in domestic violence referrals over the past three years. They took an innovative approach to strengthen their response to this increase and worked with a national helpline to create a new process to support patients to access specialist support. In addition to this the safeguarding training was strengthened on specific elements of domestic abuse.

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 followed the wider London Bridge Hospital infection prevention and control (IPC) policy, which reflected best practice and guidelines and was approved by the IPC committee. This policy included extra precautions to keep patients and staff safe during the COVID-19 pandemic.

The service performed well for cleanliness and carried out audits to assess their performance against their infection prevention and control policies. These included audits of staff uniform compliance, hand hygiene, sharps handling and disposal and waste disposal. In the 12 months prior to inspection the service had met their target for compliance in all audits for the chemotherapy ward, the outpatient department and the PET CT scanner.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Each individual chemotherapy bay had a checklist which included ensuring the bay was clean. This was completed daily.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The infection control committee met four times a year and shared reminders and learning from other departments to reduce the likelihood of infection control concerns being replicated across the hospital.

The chemotherapy day unit had an isolation bay, with a bed and chair in. Patients who had a suspected or confirmed infectious illness were cared for in an isolation bay to protect other patients.

In chemotherapy we observed nurses using the correct aseptic techniques when connecting patients to their chemotherapy. An aseptic technique is one which minimises the risk of a patient developing an infection at the injection site. The service had no chemotherapy line infections in 2021.

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 design of the environment followed national guidance. The PET CT environment was checked and approved by the environment agency and the counter terrorism unit. There were interlocks, safes and other safety precautions protecting the radioactive sources to keep patients, staff and the public safe.

The outpatient department and chemotherapy day unit had been awarded the Macmillan environment quality mark. This meant Macmillan had assessed the environment and it met a high standard that was suitable to care for patients with a cancer diagnosis.

Staff carried out daily safety checks of specialist equipment. In the PET CT scanner there were regular checks completed throughout the department. Staff checked the output of the radioactive sources upon delivery, to ensure they were fit for purpose. The radiographers also completed daily quality assurance checks on the PET CT machine before patients were injected with radioactive substances. There were maintenance contracts in case the machine broke down and this included regular specialist servicing.

In the PET CT image reporting room there were two large reporting computer screens. These were used to review images and could display high quality images with clear resolutions, to allow for radiologists to scrutinise the images carefully.

The service had suitable facilities to meet the needs of patients' families. During the COVID-19 pandemic the service had reduced the number of family members allowed on site, to reduce the risk of contamination to other patients. We were told when patients had additional needs that meant they needed a family member or carer to accompany them to their chemotherapy appointment they were cared for in a ward room, to allow them privacy and ensure the infection risk to other patients was reduced. This was arranged with prior approval. If a patient was cared for in a side room, on the chemotherapy ward, they were provided one to one nursing to ensure they were monitored at all times.

The service had enough suitable equipment to help them to safely care for patients. Each clinical area had access to resuscitation kit. This kit was checked daily by clinical staff and contained the equipment and emergency drugs needed for resuscitation.

Staff disposed of clinical waste safely. There were policies to guide staff to separate waste safely. There were specific guidelines for porters for the safe disposal of chemotherapy waste, which should be disposed of separately due to its potentially toxic nature. In PET CT there were policies and procedures to dispose of any radioactive waste. Any waste that was potentially radioactive was locked in a safe room until its radioactivity met a safe level. This was then disposed of according to criteria set by national agencies.

The chemotherapy day unit had a dirty and clean utility which reduced the risk of cross contamination with used medicines and waste.

The PET CT scanner was based in a level lower than street level. There was lift access for patients who were unable to use stairs. Staff told us the lift was fire rated, this meant it was able to be used in the event of a fire to escort patients with limited mobility out the building.

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 and had mechanisms to provide specialist support when this was required. Patients were aware of the warning signs of deterioration and were supported to seek help, if required.

Outstanding ☆

Medical care (Including older people's care)

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Chemotherapy patients had access to a 24/7 triage hotline if they were concerned about side effects when at home. All patients we spoke with were clear about signs to be concerned about. The hotline was monitored at all times by a chemotherapy trained triage nurse. There were procedures to guide staff for how to manage patients who called the hotline based on the UK Oncology Nursing Society (UKONS) criteria for managing chemotherapy side effects.

If patients needed further assessment they were admitted to the hospital for observations or other testing. If they were very unwell staff advised them to attend their local emergency department. If this was the case staff rang ahead to let the local emergency department know to expect the patient and to advise them of their concerns to ensure they were prioritised.

One known complication of chemotherapy is it can induce neutropenic sepsis. The chemotherapy day unit had a sepsis kit, including indicated antibiotics in their drug store. This meant a patient needing antibiotics did not have to wait for prescriptions to be filled by pharmacy. If a patient was identified as having sepsis it is important to rapidly administer antibiotics.

In the event a patient deteriorated while on site they were reviewed by the resident medical officer (RMO) who liaised with the patient's consultant. Patients could be admitted to the London Bridge Hospital oncology ward or intensive care unit if that level of care was required. If a patient was very unwell there were acute consultant intensivists available to care for the patient who were experienced in caring for acutely unwell patients.

Patients were regularly seen, and had access to, clinical nurse specialists. The clinical nurse specialists carried out holistic needs assessments with patients before they began a treatment regime. The holistic needs assessment asked patient preferences with regards to communication, wider support and sharing information with their GP. Where necessary patients were counselled and discussed advance directives for their care. Advanced directives are decisions patients make in advance of them being needed. They are used when a patient no longer has capacity to make decisions about their care to ensure future care is in line with their wishes.

Staff shared key information to keep patients safe when handing over their care to others. When patients had their holistic needs assessment they were asked for consent to share information with their local GP. This allowed staff to update GPs on their care and treatment and when patients were discharged from the service.

In PET CT staff ensured they had reviewed any previous imaging to ensure a new image was justified and required. Patients were asked to complete a questionnaire, which included any known allergies, to minimise the likelihood a patient would have a reaction during the scan.

All staff in PET CT had completed radiation protection supervisor training, even though it was not necessary for all staff to hold that qualification. The service lead told us this was because they believed it was beneficial for all staff to have a deeper understanding of how to manage radiation protection concerns while they were using live radiation sources.

Staffing

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

Outstanding ☆

Medical care (Including older people's care)

The service had clinical nurse specialists for each major cancer group and one palliative care nurse who supported patients who were no longer curable. Some cancer groups had multiple clinical nurse specialists due to the number and complexity of patients who needed supporting.

There were six nurses who worked on the chemotherapy day unit and provided cover between 8AM and 8PM the nurses aimed to care for a 1:5 ratio of nurses to patients. This meant they were able to closely monitor patients. The service also aimed to always have a ward manager or sister in a supernumerary role to support the nurses directly caring for patients.

There was one vacancy in the chemotherapy day unit, we were told this had been recruited into, but the nurse had not started yet. We were told if there was staff sickness staff from the oncology ward at the London Bridge Hospital would provide cover to ensure safe staffing levels could be maintained.

The PET CT service had three diagnostic radiographers. This meant they were able to rotate between seeing patients to keep their levels of radiation exposure to a minimum.

The 24/7 triage hotline for chemotherapy patients was staffed by a nurse with specialist knowledge of chemotherapy and further training to apply the UKONS triage criteria.

The service had access to other allied health professionals, including physiotherapists, dietician, pharmacists and speech and language therapists from the London Bridge Hospital. We were told there were no reported delays in a referral to a health professional being able to assess a patient.

Medical staffing

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

The service had access to a resident medical officer (RMO) at all times. Most days of the week there was one RMO who also covered other aspects of oncology. However, at times of known high demand, such as following a bank holiday weekend, there were two RMOs to ensure they were able to respond to concerns quickly.

The service worked with consultants through a practising privileges arrangement. Consultants were granted practising privileges following an application to the medical advisory committee. The medical advisory committee is explained in more detail in the well-led section of this report.

All patients were admitted under a named consultant, who was responsible for the care of their patients. If a consultant was uncontactable for a period of time, for example if they were on annual leave, they arranged for another consultant to cover their patients. We were told by nursing staff they had not known for this process to fail and were always able to contact a named consultant when they needed to.

Records

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

All patient notes we reviewed were comprehensive and all staff could access them easily. There were clear sections and the system was easy to navigate to identify any comments that had been made.

When patients transferred to a new team, there could be short delays in staff accessing their records as oncology treatment records were on a different system to the rest of the London Bridge Hospital. Staff working in chemotherapy had access to both systems but not all staff outside of oncology had access to the oncology record system. Therefore, if patients were cared for in a ward outside of oncology their records would have to be shared.

Records were stored securely and we saw all computers were locked when staff were not using them. Any paper that was used, for example consent forms, were scanned into the electronic record by administration teams.

The oncology patient record ensured consultants only worked in their scope of practice. The system was populated with predefined diagnoses and treatment pathways that consultants were approved, by their practising privileges, to use. If a consultant used a diagnosis or treatment pathway for which they had not received approval the service lead was notified, who would then investigate why this had happened.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Compliance with these processes was audited by the pharmacy team, who were available to support if concerns were identified.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. All patients were reviewed by a pharmacist on the first day of a chemotherapy cycle, or any time a chemotherapy cycle was changed. The pharmacist took a list of the medicines a patient was already taking and checked for any possible medicine interactions. Patients were then asked to update staff of any changes to medicines outside of their chemotherapy regime, this included any herbal remedies. This extra safety check was put in place to reduce the risk of patients having unexpected reactions due to medicines interacting.

Staff stored and managed medicines and in line with the provider’s policy. The chemotherapy day unit kept a small stock of frequently used medicines but did not routinely keep a stock of any controlled drugs. This was checked and restocked on a weekly basis. All medicines that were in the cupboard from the previous week were given a “use me first sticker”.

Staff followed current national practice to check patients had the correct medicines. In the chemotherapy day unit all chemotherapy infusions were double checked with a pharmacist and a nurse on delivery to the unit. Then, when the infusion was being connected to a patient this was again checked by a nurse to be correct and that the route of administration was correct.

The service was using the electronic record to support final safety checks before medicines were accepted to the chemotherapy ward or given to patients. Chemotherapy doses are patient specific and are based on the patient’s height and weight, in addition to this some drugs will not be given if a patient’s blood counts are poor. This meant there were last minute changes to prescriptions. The service was using the electronic record system to clearly display only the most recent prescription and were no longer relying on paper prescriptions to be changed and checked. This meant there was a reduction in risk of a patient receiving an incorrect dose of chemotherapy, and potentially harming them.

The chemotherapy day unit had extravasation kits, which staff were trained to use. Extravasation is when infused fluids leak from a vein into the surrounding tissues, and can be dangerous and painful.

Outstanding ☆

Medical care (Including older people's care)

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Incidents

The service managed patient safety incidents well and fostered an open culture of incident reporting. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them and told us they were happy to report incidents to allow for learning in the future. Therefore, staff raised concerns and reported incidents and near misses in line with policies.

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

Staff received feedback from investigation of incidents, both internal and external to the service. The service used “hot boards” to highlight one key safety message each week. If there had been an incident that was deemed serious enough and was potentially going to be replicated the learning from that was shared as a “hot board message”. These messages were brief and were clearly displayed in staff areas. We were told they were discussed at team briefings.

Consultants, who worked at the service under practising privileges were informed of any changes to practice following an incident over email, as they did not routinely attend team briefings.

If a serious incident occurred an immediate email was sent to all staff with initial learning and potential changes to practice identified. The service was included in the emails from the wider London Bridge Hospital, and from other hospitals in the HCA brand when learning was applicable.

There was evidence that changes had been made as a result of feedback. Following an incident where a blood test had been mislabelled there were changes to practice to make the process safer. All staff we spoke with were aware of the incident and the changes that had been implemented and told us they understood why the changes were needed.

Managers investigated incidents thoroughly and patients and their families were involved in these investigations where appropriate. Incidents were reviewed at multiple levels in the organisation. Locally the leaders were responsible for the initial review and they were supported by a link person from the governance team. If the investigation was more complex the service received more support from the governance team to complete it thoroughly and to implement any changes.

The London Bridge Hospital governance team reviewed all incident reports. They provided a second layer of scrutiny and this ensured any potential trends in incident reporting were identified and rectified. This enabled wider learning for the service and wider hospital.

Managers debriefed and supported staff after any serious incident and some less serious incidents, if staff were troubled by what had happened.

Managers ensured that actions from patient safety alerts were implemented and monitored.

Outstanding ☆

Medical care (Including older people's care)

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

Outstanding ☆

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice and implemented new practices quickly when research was published. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All chemotherapy protocols were embedded in the treatment prescribing system. Clinicians were not able to prescribe outside of these protocols without raising a formal request. This meant all chemotherapy treatment was prescribed within agreed guidelines that met national guidance.

The service was quick to introduce new treatments when they were deemed safe by national guidance. Consultants told us they found the service very responsive to requests to add new medicines or protocols to their prescribing system as they were approved by national bodies. There was an extra layer of scrutiny if consultants were requesting to add a treatment that had not yet been licensed by a national body. The consultant had to provide evidence the treatment was safe and had been tested.

In addition to consultants bringing ideas forwards the service had a “horizon scanning” team. This team reviewed publications for new technologies and treatments and made consultants aware of any new developments. This enabled the service to respond quickly and introduce new treatments where they were proven to work and approved nationally.

The service followed national guidance, provided by National Institute for Health and Care Excellence (NICE) and UKONS to identify and care for patients with sepsis. The had practical steps in place, such as having antibiotics in the medicine cupboard to reduce the time taken to treat these patients.

The team also sourced the latest evidence based treatments which were not licensed in the UK or only available through early access schemes, this was done for patients where all other treatment options had been exhausted and only if the protocol was peer reviewed by oncologist staff. The service provided a personalised stratified pathway for all patients, where patients were given individual assessments of their needs resulting in individualised care pathways. After treatment had finished patients were followed-up by clinical staff and provided with contact details for rapid re-access and referred to the provider’s cancer supportive living services.

In PET CT there were national dose requirements available for members of staff to consult, to ensure they were not giving too much or too little dose to patients. Total radiation doses were recorded for every patient, and if an exceptionally high or low dose had been given this was justified by the radiographer who had acquired the scan.

PET CT quickly integrated new knowledge into their policies and procedures, to improve the accuracy of image reporting. An example of this was the COVID-19 vaccine which increased uptake of the radioactive dye in the blood vessels on the side it was injected in, if the scan was done soon after a vaccine had been given. As a result of this they amended their pre-scan questionnaire to include COVID-19 vaccine date and asked which arm had been used. This was then available to the reporting radiologist to explain any unexpected increased uptake.

Outstanding ☆

Medical care (Including older people's care)

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. There was a menu of food available for patients to order from, patients we spoke with complimented the food offering and the quality of the food they received.

Staff fully and accurately completed patients' fluid and nutrition charts and used a nationally recognised screening tool to monitor patients at risk of malnutrition. When required specialist support from dieticians and speech and language therapists was available.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients told us they received pain relief soon after requesting it. The service was consultant led but for emerging concerns, such as pain management, the RMO or some of the more senior nurses were able to prescribe medicines. This meant patients received pain relief quickly, even if their consultant was not immediately available.

Staff prescribed, administered and recorded pain relief accurately, this was audited by the pharmacy team.

Patients were offered complimentary therapies to help manage their pain. Patients we spoke with appreciated this and told us 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 had been accredited under relevant clinical accreditation schemes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service regularly audited their adherence to a number of policies including infection prevention and control, consent and against internally set time frames. The service performed well in all audits.

Outcomes for patients were positive, consistent and met expectations. Managers and staff used the results of regular audits to further improve patients' outcomes. Outcomes were looked at for the service as a whole and for each individual consultant providing care. This enabled the service to ensure individual consultants were achieving the expected results for their patients. If an individual consultant was not achieving the results expected they would have a meeting with a member of the senior management team to understand why this was.

Managers used information from the audits to improve care and treatment. Where concerns were identified in audits the service developed an action plan. All action plans were specific to the improvements needed with nominated staff responsible, timescales and resources required. Improvement was checked and monitored by the hospital's governance team at weekly meetings.

The service used results to benchmark itself against similar services, and the NHS when this was possible.

Outstanding ☆

Medical care (Including older people's care)

The service had Macmillan accreditation which recognised services that went above and beyond to make the clinical environment welcoming and friendly for cancer patients. The service had accreditation by a nationally recognised organisation for ISO 9001:2015 standards which recognised the service's ability to monitor, manage and improve the quality of their service. The service was recognised by the European Society of Medical Oncology as a centre which provided highly integrated cancer and palliative care services.

In PET CT the time between images being taken and images being reported was regularly audited to ensure they were meeting their targets. At the time of inspection the service was working within its target timeframe. The service lead was not able to recall when they did not meet it last.

In PET CT all images were reviewed and reported on by two qualified radiologists. PET CT images are known to be open to a degree of subjectivity. In order to reduce the potential for bias in image reporting between radiologists all images were reviewed by two independent radiologists to create a report for discussion.

The PET CT team audited completion of their "pause" checklist every month. This checklist was completed before a patient was scanned and had a number of checks to be completed and signed for.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. and managers made sure staff received any specialist training for their role. All nurses in chemotherapy had completed their systemic anti-cancer therapy (SACT) competency passport or were working towards completing this. This ensured all staff understood the principles of how to care for patients receiving chemotherapy. In addition to this staff were expected to complete local competencies to demonstrate they understood and were following local policies.

Managers gave all new staff a full induction tailored to their role before they started work. Staff all had induction packs and were supernumerary for two weeks after starting. They were reviewed by the oncology practice development nurse throughout their induction process to ensure they were working safely, this also meant staff had a point of contact to ask questions to. During the COVID-19 pandemic the service was not able to hold group inductions and so had developed a video to welcome staff.

Managers supported staff to develop through yearly, constructive appraisals of their work. In addition to the annual appraisals staff had regular one to ones with their line managers, to identify any additional training they might benefit from. Additional training could then be arranged with the support of the practice development nurse.

Managers identified poor staff performance promptly and supported staff to improve. The service used a consistent system to categorise staff performance in reviews and to identify under performers. Each category had an action associated to support the staff member to improve.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Minutes were taken at all staff meetings and were shared. The governance team occasionally reviewed a sample of staff meeting minutes to ensure they included any required topics and identified learning.

Medical care (Including older people's care)

For consultants who did not have direct line managers, as they were employed under practising privileges, there was a specific system to identify poor performance. Every month concerns were reviewed by a local decision-making group made up from members of the senior management team. If consultants continued to underperform or to cause incidents their contract was terminated. This information was shared with the clinicians NHS contracted hospital and the General Medical Council (GMC), if this was required.

In the PET CT scanner all staff who worked there had completed training and competencies to do so.

Multidisciplinary working

Doctors, nurses, other healthcare professionals worked closely together as a team to benefit patients. They supported each other to provide care that centred on the patient and worked to pre-empt patient requirements.

The provider had a comprehensive multidisciplinary team (MDT) meeting policy which outlined roles and responsibilities of staff, scope of the meetings and the quality framework the meetings should follow. Regular and effective MDT meetings were held to discuss patients and improve their care. MDT meetings covered a wide range of specialities and tumour groups. Staff were able to attend these meetings in person or by video conference call and presented patient cases. Staff worked across health care disciplines and with other organisations when required to care for patients. Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Patients had their care pathway reviewed by relevant consultants.

The effectiveness of multidisciplinary meetings was audited. The number of patients discussed, the outcome and the number of days for an outcome to be agreed were all reviewed and monitored for specific tumour groups.

Staff from the service noticed there were no national standards for discussing advanced disease patients who progress through multiple lines of SACT treatment over many years, which is increasing as patients are living with cancer for longer and are thus becoming more complex. Staff at the service created an electronic MDT meeting conducted on the cancer patient management system. A consultant can present a treatment proposal in writing on the system, then tumour group specific medical and clinical oncologists, alongside medical staff from palliative care, nursing staff and pharmacy staff can review the proposal and add their comments. MDT co-ordinators collate the comments and summarise whether the treatment proposal should proceed or not.

The provider introduced a pan cancer type molecular tumour board as part of their MDT meetings to discuss the results from commercially available tests on an individual patient's tumour genetic profile. This guides treatment plans for targeted SACT, either as first line treatment or on progression from other lines of treatment. This also gives an opportunity to access available clinical trials, either at local NHS institutions or via another site managed by the provider.

Clinically the teams worked well as multidisciplinary teams. Allied health professionals told us they felt like part of the team and their opinions were respected by the consultants and nurses who were more involved in caring for patients. Patient records showed their regular input and care concerns were escalated to specialists when needed.

In PET CT radiographers told us they had good working relationships with the radiologists, this enabled them to consistently achieve their image reporting times, and to escalate images for discussion quickly where this was required.

Seven-day services

Key services were contactable seven days a week to support timely patient care.

Outstanding ☆

Medical care (Including older people's care)

The chemotherapy day was open from 8AM to 8PM Monday to Friday, excluding bank holidays. Outside of the chemotherapy day unit opening hours the service ran a 24/7 triage hotline. They were supported by the oncology ward at the London Bridge Hospital, which was open 24/7.

Outpatient clinics were booked around clinician availability. Consultants would routinely book time in the outpatient clinic around other responsibilities.

Health promotion

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

Patients were offered leaflets from a charity to support them to live healthy lives while receiving treatment. The leaflets covered a range of topics, from diet and exercise to managing side effects.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. All patients had a holistic needs assessment on their first day of treatment. This identified any support they might need which clinical nurse specialists arranged..

The service had a complimentary therapy clinic offering treatments to promote relaxation and improve mental wellness. All patients were able to access three free treatments from the service. Where it was possible, and if patients wanted, the therapist saw them while they were having their chemotherapy infusion.

Patients had the opportunity to speak with dieticians throughout their treatment to support them to continue to eat a nutritional diet when they may be feeling unwell and had lost their appetite.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Care was consultant led and the clinicians were able to carry out capacity assessments. We were told if they were concerned a psychiatrist could be contacted for support and a second opinion.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The service had audited adherence to the consent policy and found that there were omissions in consent forms. Nursing staff were not always correctly documenting when they had confirmed consent and clinicians were not always ticking all applicable boxes on the form. There were targeted action plans to improve adherence to the policy. In all records we reviewed consent was completed, confirmed and recorded correctly.

Staff supported patients to make advanced decisions about their care. This ensured if patients could no longer give consent, staff knew decisions were in line with patients' wishes, culture and traditions. Any advanced decisions about care were clearly documented and shared with the patient's GP.

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

Outstanding ☆

Medical care (Including older people's care)

Outstanding ☆

Compassionate care

Staff went above and beyond to treat patients with compassion and kindness. The service was orientated towards respecting patients' privacy and dignity and taking account of their individual needs

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. All patients were cared for in individual bays and staff followed policy to keep patient care and treatment confidential.

Patients told us staff treated them well and with kindness. All patients we spoke with were full of praise for staff. We were told staff were all "supportive and very open" when patients had questions. Patients told us staff made them "feel at home" as they were so well looked after and were "unbelievably fantastic". In addition to this the service had a folder full of letters and cards from grateful patients who had felt well cared for.

One patient told us "Everybody, from doctors to cleaners makes an effort to smile and makes me feel seen. Even with face masks on".

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff told us about the adjustments that could be made to accommodate a patient with mental health needs or other additional needs to ensure they were as comfortable as possible.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Next to the chemotherapy day unit was a quiet room.

Staff told us about an occasion where a patient was due to have a significant birthday on the same day they were due to have chemotherapy. As this was during COVID-19 patients were discouraged from having loved ones accompany them. For this occasion, the staff spoke with the patient's partner and surprised them during their treatment with their partner on the ward and a birthday cake.

Emotional support

Staff provided consistent emotional support to all patients, families and carers to minimise their distress. They made time to ensure they fully understood patients' personal, cultural and religious needs and took actions to ensure these needs were adhered to.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patient relatives we spoke with told us they were "amazed" at how accessible and open the service had been. They commented they were always able to contact somebody if they had a concern or a question and that they felt "every step of the way someone is there".

Patients commented that the support did not only come from the doctor or the nurse they were seeing but from all the other professionals they spoke with, including pharmacists, dieticians and physiotherapists.

Staff, including ward nurses and clinical nurse specialists, undertook training on breaking bad news to support them to manage difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service offered three free complimentary therapy services to patients while they were having treatment to help reduce stress and improve their general wellbeing.

As patients on the chemotherapy ward often attended for multiple treatments the service tried to keep them with a consistent member of staff, and in a consistent bay, if they requested this. We were told it gave patients an element of control over their treatment if they could choose where they sat and had the same member of staff. It also enabled them to build up a relationship and that staff member knew the patient's needs well.

The service had a single funeral director they used if a patient passed away on site. We were told the chief nursing officer and governance lead had meetings with the funeral director as part of their quality monitoring processes to ensure the service provided was in line with their standards and that families and the deceased were treated and cared for with respect.

The service and the wider London Bridge Hospital offered an annual remembrance service at a local cathedral. We were told this service was well attended by relatives of patients who had passed away and staff were invited to join too. This had not been offered in the past year, due to COVID-19 restrictions, but was planned to restart in 2022. In addition to this there was a bereavement pathway to offer support to relatives and loved ones when patients passed away.

Understanding and involvement of patients and those close to them

All staff supported patients, families and carers to understand their condition and make decisions about their care and treatment that was right for them.

Staff made sure patients and those close to them understood their care and treatment. All patients we spoke with told us they were clear about their current course of treatment and where their care pathway was leading. We overheard staff explaining procedures to patients, even if they had undergone them before, to ensure they were clear about what was going to happen.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We inspected during the COVID-19 pandemic, and many consultations were held virtually. We were told throughout the pandemic patients had been able to decide how they wanted to be seen. Even at the height of the pandemic if a patient wanted to be seen face to face it could be arranged safely. If a patient had communication difficulties they were able to be accommodated. In addition, as all staff were wearing face masks they all wore a badge with their photograph on, this way patients knew what the person who was treating them looked like.

The service had produced a range of videos with patients and clinicians for other patients to learn about different aspects of treatment at the service. These were available on their own website and social media channels. The service's IT system was soon to be upgraded to allow patients the option of downloading a patient portal to their mobile phone to enable close tracking of symptoms following treatment, with support from a nurse if anything unusual was noted.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were regular opportunities for patients to give feedback. The service not only gathered information locally but also closely replicated the "National Cancer Patient Experience Survey". The results of the survey allowed the service to benchmark itself against NHS centres.

Outstanding ☆

Medical care (Including older people's care)

Patients gave almost unanimously positive feedback about the service. In the year leading up to the inspection the service did not drop far below 100% for positive responses. The version of the National Cancer Patient Experience Survey showed the service achieved higher standards then NHS comparators in 15 of the 19 questions asked. For the remaining four questions many of the patients responded neutrally as they did not require the specific support the question was asking about. The service performed well, and better than the NHS, in the questions about patients understanding side effects and treatment options. Patients also told us they felt involved in decision making about their care

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

Good

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

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

Managers planned and organised services so they met the needs of the local population. The chemotherapy day unit had recently extended its opening hours to facilitate a wider range of appointment times. International patients were facilitated by the provider's dedicated liaison team which helped this patient group with throughout their treatment by providing services such as translation and help with paperwork and accommodation.

Facilities and premises were appropriate for the services being delivered. The service was designed to suit the needs of patients. The chemotherapy bays had been thoughtfully arranged to give patients a view over London from their chairs. All chemotherapy chairs had high backs, for support as patients were often sitting for a long period of time and televisions to provide entertainment.

The service had systems to help care for patients in need of additional support or specialist intervention. If patients had additional care needs that meant they struggled to have care in the more open day unit environment a private ward room with a one to one nurse for support was available.

Managers ensured that patients who did not attend appointments were contacted. There was a policy to contact patients if they were late for an appointment.

The service relieved pressure on other departments when they could treat patients in a day. The PET CT team told us they often accepted referrals to add patients to their list so they could have a scan after an outpatient appointment. They also told us they accepted referrals from other hospitals in the HCA brand, to support patients from other services to be seen quickly too.

The chemotherapy day unit had access to scalp cooling machines. Scalp cooling machines can help to reduce the likelihood of hair loss associated with some chemotherapy regimes. All staff were trained to use the machines and could assist patients with them.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Outstanding ☆

Medical care (Including older people's care)

Although complex patients were not seen routinely at the service, staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service provided patients with pre-treatment consultations to identify any risks and complex needs. This information was then uploaded to the electronic patient record and was used to plan each patient's experience. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had wide corridors, large bays and WC facilities to accommodate patients who were wheelchair bound.

The service had information leaflets available in languages spoken by the patients and local community and made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Patients were given a choice of food and drink to meet their cultural and religious preferences.

Patients had access to a psychologist to support them if they were experiencing emotional difficulties or mental health problems. Patients could request a referral if they wanted one, or this could be agreed in discussion with their care team.

Some patients were able to access "top up care" from the service on top of their NHS treatment. When medicines are licensed they are not always incorporated into NHS treatments, sometimes due to cost. If this was the case and a patient was deemed to possibly benefit from this medicine the service allowed the patient to have most of their treatment in the NHS and to receive the "top up" treatment from them as a self-paying patient. This gave patients an option to have treatments that were otherwise not available to them on the NHS, without having to pay for the whole treatment course.

The service provided training to patients to self-administer certain drugs. This meant patients who lived far away from the service did not have to visit so frequently. During COVID-19, a courier service was provided for all oral chemotherapy to ensure vulnerable patients were protected and did not have to travel.

The quiet room had multiple religious texts and had space for patients to pray. They had disposable prayer mats to ensure patients could pray safely, and not risk cross contamination. The service also offered a chaplaincy service for all patients 24 hours a day seven days a week for further spiritual support.

The service provided patients with a 'patient passport' this was a document where patients could record their preferences for care and treatment and meant they did not have to explain these to every healthcare professional they met.

The service offered a living with and beyond cancer programme to support patients who have experienced cancer adapt to life following a cancer diagnosis. This initiative included patient forums and online exercise programmes to provide holistic support.

Access and flow

People could access the service when they needed it and received the right care promptly. The service offered a no wait service for patients once treatments had been agreed. The service used its counter parts within the brand to support timely access to care.

The service ran a "no wait" service for patients. Patients were given the ability to control how quickly the pathway moved and could book appointments to suit their needs. We were told if a treatment was agreed at MDT the patient could normally start treatment the next day, if they wanted to.

Outstanding ☆

Medical care (Including older people's care)

The service monitored its activity year on year. During 2020, and the original peak of the COVID-19 pandemic, the service increased the number of chemotherapy cycles delivered compared with the same time frame in 2019. This number had increased again in 2021. This demonstrated the service had maintained, and increased access to patients throughout the pandemic.

Managers worked to keep the number of cancelled appointments to a minimum. In PET CT the service worked closely with other PET CT services in the HCA brand to accommodate as many patients as possible, if another scanner was unable to be used. Staff in the chemotherapy unit tried to keep appointments to a minimum for a patient, and combined treatment days with any other procedures necessary, such as port fitting.

When patients had their appointments or treatments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. PET CT staff told us they occasionally had to cancel patients, if there was a problem with the delivery of the radiation sources. If this happened, staff would first try to book them into another PET CT scanner from the HCA brand on the same day. If this was not possible, staff would rebook the appointment as soon as possible.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns formally, although all patients we spoke with told us if they had a concern they would just speak with a member of staff.

In the 12 months before the inspection the service had received four complaints. After investigation only one complaint had been upheld.

Managers investigated complaints and identified themes. Although complaints were mostly investigated locally, the governance team at the London Bridge Hospital also had oversight of all complaints. This team supported with thematic reviews of complaints and identified trends and subsequent required changes to practice.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

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

Good

Leadership

Leaders had the skills and abilities to run the service. They understood and carefully managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They actively supported staff to develop their skills and take on more senior roles. Consultants were actively involved in the development and monitoring of the service and were committed to driving excellent patient care.

Outstanding ☆

Medical care (Including older people's care)

Leaders were experienced and had backgrounds managing services within the NHS. To enhance their leadership skills, they were offered further training and were able to apply for funded spaces on recognised leadership courses.

The service had a new matron within the past year. Upon arriving they told us they were happy with how things were running clinically but felt there was a need to create a supportive culture where staff felt led.

The service knew the value of retaining high quality staff and supporting them with training to allow for succession planning. Staff were able to access funded courses to support them to develop skills. In the chemotherapy unit there had recently been staff promotions, the newly senior staff were being supported by their managers. Peer to peer learning was encouraged by a weekly ward manager meeting, to share learning and to talk through any concerns they had together.

All staff we spoke with knew who the senior leadership team were, the senior leaders also knew all their staff by name. The matron of the oncology service had introduced “matron clinics” where every Tuesday afternoon staff could bring any concerns or ideas to them and made themselves accessible for staff.

Vision and Strategy

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 increasing access to new treatments. Leaders and staff understood and knew how to apply them and monitor progress.

The service’s plan was part of the wider London Bridge Hospital plan. It was developed with heads of department and service leads. The plan was monitored by the wider London Bridge Hospital governance team and was regularly checked for progress against targets. The targets for 2021 had not all been met. We were told this was because the impact of the COVID-19 pandemic into 2021 had been underestimated and meant the service had to reassess priorities and moved some to the following year to prioritise safety over development.

The plan was shared with staff and was written in a way that meant targets were clear and understandable. It was also shared with the wider HCA brand and formed part of the wider business plan.

There were local values and also wider brand values. Staff we spoke with were aware of the values and how these impacted on the care they delivered day to day. All staff attended a training session about values during their induction to ensure they were clear about what was required of them.

The service was working towards the brand goals of strengthening relationships between all their hospitals and services. This strategy had been launched shortly before our inspection and the service was in the process of working out how to integrate their local vision and strategy with this wider vision.

At the time of inspection, the service was writing their next plan. In previous years they had created annual plans, this time were forward planning for the next 3-5 years to set ambitious targets.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns or suggestions without fear.

Outstanding ☆

Medical care (Including older people's care)

All staff we spoke with were enthusiastic about working for the service. They told us they were happy to work for the service and they were pleased they could deliver the level of care they did. Many members of the team had worked at the service for a number of years and told us they continued to do so because they were able to deliver a level of care they had not been able to in previous roles. All members of the multidisciplinary team told us they felt able to speak up and that they would be listened to if they had a concern.

The matron told us when they joined the service they felt the team lacked leadership and team morale was low. To combat this they introduced “star of the month”. Staff were encouraged to nominate one of their colleagues each month they felt had excelled. As this was peer to peer recognition, and not management recognition, the matron felt it meaningfully bought staff members, and teams together as they could see how valued they were.

The service used a categorisation system for all staff in regular appraisals to support managers to consistently identify staff members who were in need of support to reach their goals and to progress and those who were excelling. The service had recently created a new position of a post graduate training nurse for cancer in recognition of the need to proactively support staff to develop to improve retention rates. Part of this nurse’s remit was to support members of staff to identify and apply for courses.

The RMOs regularly had meetings with the matron, to ensure they were informed of any changes to pathways or new practices that were coming into use soon. We were told they were treated as part of the team and it was acknowledged they needed to be a part of regular discussions, to support patient care.

If there had been an upsetting incident during the day staff were offered the chance to debrief about it to ensure they did not take anxiety about the incident home. In addition to this staff were able to access formal psychological support. This offer had been increased during the COVID-19 pandemic as it was recognised staff were likely to be increasingly concerned about working safely and the safety of their patients.

The service had freedom to speak up guardians in role to provide staff with alternative members of staff to raise concerns with, if they felt unable to speak to their manager. The freedom to speak up guardian role was promoted using meetings and noticeboards.

Governance

Leaders operated effective governance processes, throughout the service, with partner organisations and throughout the wider brand. 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 service had multiple lines of governance, with oversight from different groups. Locally the service reported into the wider London Bridge Hospital governance framework and it was supported by the local governance and quality teams. The service also reported into the governance framework covering the other three Leaders in Oncology Care services across London. They had regular meetings to ensure patients were offered equitable care across all sites. In addition to this the service fed up into the wider HCA brand governance channels, this was facilitated through the London Bridge Hospital governance meetings.

Locally there were regular staff meetings to make staff aware of any actions or learning. There were minutes taken for staff who were not able to attend. Following the inspection, the service sent us a selection of minutes to review. The minutes were easy to follow, identified required actions, with dates for completion and people responsible for actions.

Medical care (Including older people's care)

The service had a named link member of the London Bridge Hospital governance team to support them with any governance queries or concerns. They supported with responding to complaints or investigating complex incidents and ensuring action plans were adhered to.

The service was represented at the London Bridge Hospital medical advisory committee meetings. The medical advisory committee advised on matters such as granting practising privileges, scope of practice for consultants, reviewing patient outcomes and implementing new guidance or techniques. Decisions made at medical advisory committee were final. In addition to the hospital medical advisory committee there was another medical advisory committee with the other Leaders in Oncology Care services, based in other locations. This promoted consistent decision making and comparisons were made between the services.

The Leaders in Oncology Care services also ran “cancer boards”. Each tumour type had a cancer board group associated with it and one consultant was nominated as the chair for every board. Their remit was to set and approve guidelines for treatment, set targets for diagnosis, treatment and follow up and to discuss any new developments the service might want to implement. Following each individual tumour group cancer board meeting the chairs all met for one central meeting to share outcomes.

The service had protocols for consultants to prescribe medicines off-licence if this was not already standard practice. Off-licence prescribing refers to medicines being prescribed for uses other then those they are formally licensed to be used for; it is a common occurrence. If a consultant wanted to prescribe a medicine off licence they had to formally apply to do so, with evidence to support he safety and efficacy of doing so. This application was then reviewed by other consultants and the pharmacy team and could only be progressed if it was agreed to be a safe, and likely effective, treatment for the patient.

Management of risk, issues and performance

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

The service had a risk register for both the chemotherapy day unit and the PET CT scanner. The risk registers defined the risk, identified the level of risk, any mitigating actions already in place, any future actions and dates for review. Most risks were reviewed every three months. The exception to this was the “accepted risks”. Accepted risks were noted where an activity was inherently risky and the service had done all they could to mitigate it. These were reviewed annually.

The service took part in the regular audit programme set by the wider London Bridge Hospital. This ensured staff were complying with policies and protocols. If the service was not achieving their targets action plans were written up to improve compliance. Action plans were then monitored locally, with oversight by the central clinical governance team.

The service had a financial arrangement with the NHS trust it rented the space from. If the service made above a certain level of revenue a proportion of this was shared with the NHS trust. We were told this was not in place to incentivise the NHS trust to refer patients to the service but, was instead a mutual relationship that meant the NHS trust benefitted when the service was doing well. Clinicians who worked for the service told us they were happy this arrangement existed as it meant NHS patients benefitted from the private service.

The service had an emergency response plan, in the event of an unexpected incident happening. The plan had defined responsibilities, actions and communication plans. The plan included contact telephone numbers for different emergency agencies or specialist authorities.

The PET CT service had specific emergency response plans to ensure the radioactive sources were kept secure in the event of an emergency. All automatic locking systems were backed up with physical locks and there were further security measures in the room the radiation was stored. There were regular reviews of these plans in case changes were needed. The service consulted with the environment agency and the counter terrorism unit to ensure they met the requirements to keep patients, staff and the public safe.

Information Management

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

The service shared the audit results and any action plans with staff. This meant staff were aware of any changes or modifications to practice that were required to improve safety.

The service collected data on patient outcomes and was able to split this in many ways, including by individual consultant. This meant if there was a concern about an individual consultant the team were able to look at their patient outcome data and compare it against their peer's data. Therefore, the service was able to draw conclusions about whether consultants were performing poorly generally.

Information governance training formed part of the mandatory training programme, the service was compliant with this training. While we were on site we observed all computers were locked, when they were not in use, meaning patient information was secured.

The service shared key messages with staff in a number of formats, to ensure the key messages were received by all staff. They used "hot boards" in staff areas, emails, staff huddles and formal staff meetings. This ensured staff were made aware of important messages.

The service used a specific oncology patient record, that was separate to the main hospital patient record. This record had functionality and safety check points the generic patient record, used by the rest of the hospital, did not and was specifically designed for use with oncology patient pathways. It was an identified risk that the two records were not compatible and did not interface with each other. However, if patients required admission to the hospital they were almost all cared for on the oncology ward and staff there had access to the oncology record. For the few patients who required care in the critical care ward information could be shared by staff.

Engagement

Leaders and staff actively and openly engaged with patients, staff, and local NHS organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged with patients for changes about any proposed changes to the environment to try and meet their preferences. Recently the service had redecorated the complimentary therapy room and patients were asked to vote for their preferred wallpaper.

The service ran a specific support group for breast cancer patients. This group was asked to support the development of new patient leaflets, to ensure they contained the information patients felt was important for future patients and were easily understood.

They used an online application available to all staff as a virtual "suggestion box". This meant all members of staff were able to suggest new ideas at any time. Any new suggestions were reviewed by the service lead.

The service had recently run a patient safety conference and had asked for all teams to produce a poster about an innovative change in their department and to present this at the conference.

Consultants were able to suggest and, where there was evidence to back its safety, introduce new treatments or use new technologies at pace.

Throughout the COVID-19 pandemic, including when we inspected, the service had supported their local NHS trusts. At the beginning of the pandemic they held discussions with the NHS trusts about the care they could safely support. As the London Bridge Hospital provided elective care they were able to maintain a more controlled environment This led to the service taking patients who were particularly at risk of contracting COVID-19 and caring for them in their environment. A number of pathways were moved to the service, and NHS staff were granted temporary practising privileges to maintain continuity of care for their patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service had a "horizon scanning" team who were responsible for identifying new medicines and other new advances in treatment to improve the care of cancer patients. The team shared any potential new innovations with the specific tumour group meeting they would be used for. The tumour group specialities then discussed whether the new innovation would positively impact on the care they were able to deliver and whether it met an unmet need. If it was agreed, protocols were drafted, in preparation for the medicine being licensed, meaning as soon as the medicine was able to be used in England the service was ready to use it.

The service consistently expanded their use of immunotherapy medicines to offer a wider range to patients. Immunotherapy treatments are a relatively new, and quickly expanding, range of treatments that use the body's immune system to find and attack cancer cells. The consultants involved in this were experts in the area and included the pharmacy team in discussions to ensure patients were clear about potential side effects. All patients who were on an immunotherapy regime were given a card to identify this to other healthcare providers, who were not involved in their cancer care. The pharmacy team had created a generic card, so patients only needed to keep one card on them, even if they were on a number of different medicines.

The service planned to introduce chemotherapy research trials and join an established research institute, under the wider HCA brand. Due to the extra pressures of the COVID-19 pandemic the service had identified this needed to be delayed. However, patients who were eligible for research trials were referred to another Leaders in Oncology Care service, that had already established links with the research institute.

In response to the rise in domestic abuse during the COVID-19 pandemic the service had strengthened pathways and support for patients, who were or were at risk of domestic abuse. They were developing a new dedicated training module addressing this, due to be launched soon following inspection.