The London Gamma Knife Centre at Barts

Quality Report

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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	Good
Are services safe?	Good
Are services effective?	
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The London Gamma Knife Centre at Barts is an independent health service provided by HCA International Limited. It provides stereotactic radiosurgery (SRS) or stereotactic radiotherapy (SRT) for adults with certain brain tumors, using a stereotactic frame and cobalt source machine.

The service provides advance radiotherapy services to both NHS and private patients. It is located within Saint Bartholomew's Hospital, which is part of Barts Health NHS Trust. Patients are referred from around southern and central England in to the NHS trust and then onwards to The London Gamma Knife Centre at Barts.

The London Gamma Knife Centre at Barts (LGK) treats patients on a day case basis with provision made for overnight stays in the NHS trust or another HCA facility, which is sometimes required post treatment. It is provided from a basement location in the NHS hospital it works in partnership with and comprises of a treatment room, where the Gamma Knife machine is located, three resting bays for patients, a reception and staff areas. Between July 2015 and June 2016 the service reported 197 cases treated.

As a small service, it is incorporated into the governance and oversight structure of The Harley Street Clinic which also provides radiosurgical services. This is a larger acute hospital also run by HCA International and located nearby.

We carried out an announced inspection of the service on 6 December 2016 and returned, unannounced, on 14 December 2016. We visited all parts of the premises including the treatment room, patient resting bays, reception and staff areas.

To help us come to our ratings we spoke with eight patients (and relatives) by telephone, chosen at random, who had recently completed both Gamma Knife treatment and follow up. We spoke with ten members of staff from a range of specialties and areas of responsibility, including clinical and non-clinical staff. This included consultants, clinical research fellow, chief executive, patient pathway coordinator and non clinical services manager, lead radiotherapist, radiographer, governance lead, chief physicist and chef.

We reviewed over 70 documents relating to the running of the service that were requested prior to and during our inspection. In addition to this we reviewed information while on site, including treatment logs, training records and sets of patient records including assessments and treatment plans.

Our key findings were as follows:

Are services safe?

- There was a very low rate of incidents and systems were in place to report, review, investigate and learn from incidents.
- The service was clean and hygienic and the Gamma Knife treatment room was secure. Equipment had been appropriately serviced and inspected and was safe.
- The service was adequately staffed.
- Patient risk was appropriately assessed and responded to and resuscitation equipment was in place and suitably checked.
- Patients were rested in one of three curtained bays which were adequately equipped.
- There was good joint working with the NHS hospital to ensure appropriate assessment took place.
- Although the service looked out for vulnerability and treated people's welfare as a priority, there was a lack of understanding about safeguarding procedures and processes.

Summary of findings

- Training was recorded as falling below the low expected compliance level of 81%.
- Patients were able to choose to walk, accompanied, back to the service once the stereotactic head frame had been fitted, which had not been formally risk assessed.

Are services effective?

- Effective was inspected but has not been rated. This was because the capturing of patient outcomes was difficult to achieve due to the nature and referral patterns for the service.
- Quality assurance, professional accreditation and benchmarking had taken place.
- Patient treatment eligibility was in line with criteria defined by the NHS commissioning board's clinical commissioning policies.
- There were clearly defined professional roles, with competent staff to fulfil these roles.
- There were good arrangements in place for multidisciplinary working and joint working with the referring NHS hospital.
- There were suitable arrangements in place for gaining patient consent, with opportunities for patients to ask questions about their treatment.

Are services caring?

- Patients told us that undergoing Gamma Knife treatment could be an anxious time and that staff took in to account that people may be nervous and helped them manage this through their supportive approach. Patients told us this made a significant difference to their overall experience of the service.
- Staff took the time to explain treatment to patients. Patients felt involved in their own treatment and decisions regarding their treatment. Family members and friends who accompanied patients also felt included.
- The service was caring and compassionate in its approach.

Are services responsive?

- There was an increase in demand for the service and The London Gamma Knife Centre at Barts (LGK) had taken appropriate steps to respond to this as well as introduce measures that enabled the best use of treatment time.
- Patients with malignant tumours received timely treatment. The service aimed to treat patients within 14 days. Referral to treatment averaged at around 9 days.
- Patients and referring services received prompt treatment summaries.
- Treatment was planned and delivered in ways that met people's needs and the service listened to patients' preferences and accommodated these.
- Assessments identified people's individual needs, which were being met.
- There were systems in place to effectively respond to concerns and complaints.
- Although the service triaged patients appropriately there was delayed access to treatment for benign patients.

Are services well led?

- There was operational, clinical and non clinical leadership and clear lines of accountability within the service**.** There was a visible leadership presence and regular rounding by the executive.

Summary of findings

- The London Gamma Knife Centre at Barts (LGK) was a small service that had been incorporated into the governance and oversight structures of a nearby acute hospital that also provided radiosurgical services, and belonged to the same provider company, HCA International. We were satisfied that the LGK voice, and issues pertinent to the service benefitted from this arrangement.
- There was also a meeting structure that was exclusive to LGK, with accountability and assurance that fed in to the larger structure.
- There was a clear vision, strategy and improvement plan. Innovation incorporated working with demand and delivering a quality service.

The provider should therefore ensure that:

- Staff have a working knowledge of when it might be appropriate to escalate potential safeguarding issues.
- Training levels were below the already low 'green' rating of 81%. The provider should assure itself that training attendance is at an acceptable level and issues from recording training in the new system are resolved.
- Patients are formally risk assessed to be able to choose to walk, accompanied, back to the service once the stereotactic head frame had been fitted.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

What people who use the service say

What patients told us

We spoke with eight patients who had completed both treatment and follow up. Everyone told us that staff made them feel at ease, spoke to them in a caring manner and always had time to answer their questions.

Patients told us: “I was a bit nervous. They reassured me”. Another told us “they were very caring. I am not the bravest of people and they were very understanding”. “The MDT were all there taking an interest in it. They really put me at ease.” “Really pleased how it all went. Care, communication was great. All in all I couldn’t have asked for more.”

Everyone we spoke with told us they felt involved in treatment and included in decisions. Patients told us: “we received information beforehand and (the treating consultant) talked us through it. A nurse talked us through the treatment.” “From the time I got there everyone explained everything to me.” “They also kept my sister informed and involved her.” “They definitely made my husband feel included.” “No one was too busy to talk to you and explain things.” We received one comment that related to the amount of time treatment took over the expected waiting time, incurring a large parking fee.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There was a very low rate of incidents and systems were in place to report, review, investigate and learn from incidents.
- The service was clean and hygienic and the Gamma Knife treatment room was secure. Equipment had been appropriately serviced and inspected and was safe.
- The service was adequately staffed.
- Patient risk was appropriately assessed and responded to and resuscitation equipment was in place and suitably checked.
- Patients were rested in one of three curtained bays which were adequately equipped.
- There was good joint working with the NHS hospital to ensure appropriate assessment took place.
- Although the service looked out for vulnerability and treated people's welfare as a priority, there was a lack of understanding about safeguarding procedures and processes.
- Training was recorded as falling below the low expected compliance level of 81%.
- Patients were able to choose to walk, accompanied, back to the service once the stereotactic head frame had been fitted, which had not been formally risk assessed.

However:

- Although the service looked out for vulnerability and treated people's welfare as a priority, there was a lack of understanding about safeguarding procedures and processes.
- Training was recorded as falling below the low expected compliance level of 81%.
- Patients were able to choose to walk, accompanied, back to the service once the stereotactic head frame had been fitted, which had not been formally risk assessed.

Are services effective?

Effective was inspected but has not been rated.

- This was because the capturing of patient outcomes was difficult to achieve due to the nature and referral patterns for the service.
- Quality assurance, professional accreditation and benchmarking had taken place.

Summary of this inspection

- Patient treatment eligibility was in line with criteria defined by the NHS commissioning board's clinical commissioning policies.
- There were clearly defined professional roles, with competent staff to fulfil these roles.
- There were good arrangements in place for multidisciplinary working and joint working with the referring NHS hospital.
- There were suitable arrangements in place for gaining patient consent, with opportunities for patients to ask questions about their treatment.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- Patients told us that undergoing Gamma Knife treatment could be an anxious time and that staff took in to account that people may be nervous and helped them manage this through their supportive approach. Patients told us this made a significant difference to their overall experience of the service.
- Staff took the time to explain treatment to patients. Patients felt involved in their own treatment and decisions regarding their treatment. Family members and friends who accompanied patients also felt included.
- The service was caring and compassionate in its approach.

Are services responsive?

Good ●

We rated responsive as good because:

- There was an increase in demand for the service and The London Gamma Knife Centre at Barts (LGK) had taken appropriate steps to respond to this as well as introduce measures that enabled the best use of treatment time.
- Patients were receiving timely treatment. The service aimed to treat patients within 14 days. Referral to treatment ranged from zero days to 42 and averaged at around 9 days.
- Patients and referring services received prompt treatment summaries.
- Treatment was planned and delivered in ways that met people's needs and the service listened to patients' preferences and accommodated these.
- Assessments identified people's individual needs, which were being met.
- There were systems in place to effectively respond to concerns and complaints.

However:

Summary of this inspection

- Although the service triaged patients appropriately there was delayed access to treatment for benign patients.

Are services well-led?

Good

We rated well led as good because:

- There was operational, clinical and non clinical leadership and clear lines of accountability within the service**.** There was a visible leadership presence and regular rounding by the executive.
- The London Gamma Knife Centre at Barts (LGK) was a small service that had been incorporated into the governance and oversight structures of a nearby acute hospital that also provided radiosurgical services, and belonged to the same provider company, HCA International. We were satisfied that the LGK voice, and issues pertinent to the service benefitted from this arrangement.
- There was also a meeting structure that was exclusive to LGK, with accountability and assurance that fed in to the larger structure.
- There was a clear vision, strategy and improvement plan. Innovation incorporated working with demand and delivering a quality service.

Good

Medical care

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

Information about the service

The London Gamma Knife Centre at Barts is an independent health service provided by HCA International Limited. It provides stereotactic radiosurgery (SRS) or stereotactic radiotherapy (SRT) for adults with certain brain tumours, using a stereotactic frame and cobalt source machine.

The service provides advance radiotherapy services to both NHS and private patients. It is located within the NHS hospital it works with. Patients are referred from around southern and central England.

The London Gamma Knife Centre at Barts (LGK) treats patients on a day case basis with provision made for overnight stays in the NHS trust or another HCA facility, which is sometimes required post treatment. It is provided from a basement location in the NHS hospital it works in partnership with and comprises of a treatment room, where the Gamma Knife machine is located, three resting bays for patients, a reception and staff areas. Between July 2015 and June 2016 the service reported 197 cases treated.

As a small service, it is incorporated within the governance and oversight structure of a nearby larger acute hospital belonging to the provider company HCA International, which also provides radiosurgical services.

Are medical care services safe?

Good

We rated safe as good because:

- There was a very low rate of incidents and systems were in place to report, review, investigate and learn from incidents.
- The service was clean and hygienic and the Gamma Knife treatment room was secure. Equipment had been appropriately serviced and inspected and was safe.
- The service was adequately staffed.
- Patient risk was appropriately assessed and responded to and resuscitation equipment was in place and suitably checked.
- Patients were rested in one of three curtained bays which were adequately equipped.
- There was good joint working with the NHS hospital to ensure appropriate assessment took place.

However:

- Although the service looked out for vulnerability and treated people's welfare as a priority, there was a lack of understanding about safeguarding procedures and processes.
- Training was recorded as falling below the low expected compliance level of 81%.
- Patients were able to choose to walk, accompanied, back to the service once the stereotactic head frame had been fitted, which had not been formally risk assessed.

Incidents

- In the reporting period (July 15 to June 16) there had been zero Never Events. 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.

- In the reporting period (July 15 to June 16) there were four clinical incidents. Of these incidents two were categorised as no harm, one was categorised as low harm and one as moderate, none were categorised as severe and none were categorised as a death. In the same reporting period there were zero serious injuries.
- Incidents were reviewed at the medical advisory committee (MAC) meetings and feedback took place at operational meetings. The London Gamma Knife at Barts (LGK) was a small service. For shared learning, they were included within the governance structure of the provider company's nearby acute hospital The Harley Street Clinic (THSC), which also provided radiosurgical services. Staff reported all incidents and near misses through an online incident reporting system which were managed through this governance process so that learning could be promptly identified and cascaded.
- For incidents that related to patients who had been referred by the NHS, the procedure was to make two incident reports; one for input on the HCA system and one for the NHS system. Information was shared with Saint Bartholomew's Hospital, (the referring NHS hospital) via email on a case by case basis. Staff attended multidisciplinary meetings with the NHS hospital where, for the purposes of shared learning, incidents were discussed.
- The most recent incident occurred in August 2016. An incident meeting was held to discuss findings and included the lead clinical oncologist for HCA. We were provided with the incident report, details of the incident meeting, recommendations and details of the designated staff with responsibility to implement them, signed off by the superintendent radiographer and chief medical officer for the provider.

Cleanliness, infection control and hygiene

- On both our announced and unannounced visits the environment appeared clean, hygienic and free of any signs of dirt or dust. Cleaning staff were from an outsourced company and attended every morning for between an hour and an hour and a half. The company's supervisors carried out monthly inspections for water segregation and quarterly inspections for hygiene of the environment. The reports were shared with LGK. Supervisors were available to speak with if there were any issues. LGK managers also attended meetings with the director of operations at the NHS hospital they worked in partnership with, who oversaw the cleaning contract.
- The infection control lead was based at THSC who was available for advice and had oversight of the hand hygiene audits. The lead therapy radiographer told us the infection control lead was available for contact whenever advice or guidance was needed.
- In the reporting period (July 15 to June 16) there were zero incidences of hospital acquired MRSA, acquired methicillin-sensitive Staphylococcus aureus (MSSA), acquired Clostridium difficile (C.diff) or acquired E-Coli.

Environment and equipment

- The service was located in the basement of the NHS hospital that it worked in partnership with. It consisted of a treatment area, three patient resting bays, a clinicians' office with four desks, a reception area and a toilet. Access was via a patient lift or stairs from the ground floor.
- The service utilised the MRI and CT scanners from Saint Bartholomew's Hospital's radiology department for the treatment and planning of LGK patients. This was arranged as part of a service level agreement with quality assurance and safety testing being the responsibility of the NHS hospital's radiology department.
- Patients were rested in one of three curtained bays which were equipped with observational equipment. Patients sat in special chairs capable of reclining and becoming flat for resuscitation if needed.
- There was resuscitation equipment present within the service. Due to limited space this was not located on a trolley but all contents were available. The kit was sealed and appropriate checks had been made for three months records we saw up to the date of inspection (October 2016 – December 2016). A Resuscitation Council compliant checklist had not been in use until December 2016. The reason for this was given as the kit and checklist, which only included the date and tag number for a check, was provided by the NHS hospital

that it worked in partnership with. LGK had identified this as an issue and had corrected it by using their own compliant checklist. A defibrillator was available and in order.

- Joint radiation and medical exposure committee meetings were held quarterly with THSC that also had a radiology department.
- The service conducted daily quality assurance checks to ensure the machine was functioning properly before the start of any treatment day. Medical physics would also perform more advanced monthly and annual quality assurance tests. We were shown evidence of this. All staff we spoke with confirmed that it was easy to secure machine and equipment upgrades.
- Medical physics had completed a radiation dose level audit for the treatment room, which allowed the department to identify how much radiation dose was received in different parts of the treatment room. This was useful in identifying dose hotspots and the safest area of the room whilst the machine was active in case of emergencies.
- The machine used a cobalt source to produce radiation for treatment. The age of the source was increasing which subsequently resulted in longer treatment times for patients. LGK were looking into replacing the machine in the near future. An upgrade of the Gamma Knife machine was part of the medium term plan in order to decrease the length of treatment time and to keep up with patient demand.
- There was an annual Environment Agency inspection to review the safety of the radiation source. We saw evidence of regular daily, monthly and annual quality assurance testing of the Gamma Knife machine.
- Radiation warning lights were in place; one lit up and stated 'controlled area risk of external exposure'. There was also signage stating 'radiation controlled area, sealed radiation sources' and the symbol. Fire exits were clearly marked.

Medicines

- Treatment involved the fitting of a head frame and being placed in to an enclosed space. Patients occasionally suffered from anxiety or claustrophobia and could be prescribed a sedative (lorazepam) to ease these symptoms. Paracetamol and ibuprofen were kept for post treatment pain relief if needed.
- Controlled drugs were stored securely. The controlled drugs cupboard was inside the drugs cupboard andsecured with an extra lock. Keys were kept in a pin accessed key safe.
- Pharmacy came under the governance structure of THSC, who did medicines management and fridge audits every quarter.

Records

- Patient records were recorded in both paper and electronic form. Paper records were then scanned in to the electronic record. Records held included referral letters, MDT outcome records, discharge summaries and records of treatments undertaken.
- A new database was now being used by the service provider to store all current patient information. All previous records were being scanned in to this system.

Safeguarding

- Although the service looked out for vulnerability and treated people's welfare and wellbeing as a priority, there was a lack of understanding about safeguarding reporting processes.
- We were given examples of how LGK had worked positively with people who had been in any way vulnerable. In one example we were given, appropriate support and care was given to one person who was eventually sectioned under the Mental Health Act. Despite this we were told that no potential safeguarding incidents or issues had arisen and there had never been a need to seek advice about any potential safeguarding issues. Reporting to the local safeguarding authority was not referred to during these examples. Staff we spoke with were not aware of who within the service took responsibility to report any potential harm or abuse.
- Safeguarding came under the governance structure of THSC where the safeguarding lead was based. We were told advice could be sought from them when needed. The safeguarding lead carried out both local and corporate induction and attended the provider's senior

sisters' meetings, senior managers' meetings and also chaired the safeguarding committee. We were provided with a flow chart that described the process of escalation.

- Training was mandatory and web based. It consisted of safeguarding children levels 1 and 2, and adult safeguarding level 2. Attendance was below the 81% compliance level set by the provider.

Mandatory training

- The provider company, HCA, had introduced 'the learning academy' this year. Staff training was now recorded within this new system. Heads of departments would now have access to training records and responsibility to chase up poor attendance. If training attendance was also checked at annual appraisals.
- We were shown the database for recording training. Topics included basic life support, clinical induction, corporate induction, dementia and disability awareness, duty of candour, equal opportunities and diversity, ethics and code of conduct, fire safety, health and safety, information governance, manual handling, governance, mental capacity and deprivation of liberty safeguards. The total compliance level was an average of 73% for the radiosurgery team. The provider company's acceptable training level was set at the relatively low level of 81% which was red/amber/green (RAG) rated. For the physics team, there was an average of 78% attendance. Out of 13 physics employees, three were rated green, the rest amber.
- In mitigation, managers accounted for non-attendance by stating that the new academy system had technical issues with the recording of attendance for electronic modules. Long term sickness had also affected this statistic and they were waiting for a booking for staff to attend the practical element of manual handling training. Also level 3 safeguarding children had been attended by all staff but had not been recorded.

Assessing and responding to patient risk

- Patients were referred from around southern and central England into the care of Saint Bartholomew's Hospital, part of Barts Health NHS Trust, who then referred them to LGK for treatment and follow up. Patients were then discharged back into the care of the NHS hospital, who discharged them back to their referring authority. A discharge summary was completed on the day of treatment, which went to the NHS hospital, the referring authority, the patient and GP. It contained details of treatment given, doses of radiation, and any risk issues identified in the assessment process.
- The multidisciplinary team (MDT) initially assessed patients against eligibility criteria that was based on the number and volume of lesions, brain metastases and a life expectancy of greater than six months.
- Once referred, and at the pre assessment stage, the clinical nurse specialist (CNS) risk assessed against a number of factors such as allergies, medications, arteriovenous malformation, bloods required, presenting conditions, past medical history, kidney problems, alcohol intake, vital signs and mobility and any other additional relevant information. After the CNS had identified any risk issues, they were shared with the MDT as well as on the day of treatment.
- There was identification of specific issues to be addressed such as whether the patient was able to lie flat or whether they were claustrophobic (treatment for Gamma Knife and MRI meant lying flat and being in an enclosed space). If patients were overly nervous or anxious, a sedative (lorazepam) could be prescribed.
- Female patients were asked if they were pregnant. If there was any doubt, pregnancy testing kits were available. A radiographer told us that on the day, if there were any doubts when they asked women, they would carry out a test.
- A treatment plan checklist and MRI safety questionnaire were also completed on the day of treatment and an identity check was done with all patients. Patients gave their full name, date of birth and first line of their address. Then there was a check of the treatment plan against the plan that had come up on LGK records. Consent was signed by the patient and consultant, allergies were checked as well as laterality (right or left side). On the radiographer check sheet for MRI, patients consented on the morning of treatment.
- Due to patients needing to be planned prior to being treated the patient must have a MRI scan which was owned by the NHS hospital's radiology department. The scan was performed before the NHS hospital's opening hours or additional time was negotiated between the

department leads. The scan was performed by the NHS radiographers. However, the LGK radiographer and CNS were always present to assist and tend to the patient care needs.

- Contrast media risks were managed as standard with a patient safety questionnaire given prior to the scan. This questionnaire also confirmed patient details and if any metal was present in the body. Anaphylactic flow charts were in place in the scanner control room.
- The frame fitting area was located next to the MRI scanner. This was a recovery room and was shared between LGK and the NHS hospital. The consultant fitting the frame was present until the patient was taken back to the site of the treatment provided by LGK.
- The clinical nurse specialist (CNS) was always present throughout the patient pathway and to attend to patients in a first response situation. Although these incidents were very rare and if they did occur it was usually the patient feeling light headed and fainting caused from the pressure of the head frame. Patients were not permitted to be unattended once the frames were fitted. Patients were rested in one of three curtained bays that were equipped with observational equipment. Patients sat in special chairs capable of reclining and becoming flat for resuscitation if needed. The service was able to call on the NHS hospital's crash team. A crash kit was present at LGK. The kit was sealed and checks had been carried out as appropriate. A defibrillator was available and in order.
- We were told that once the head frame had been fitted, patients were transferred via wheelchair and with a nurse escort from the radiology department to the LGK's premises, which involved taking two lifts and going across the NHS hospital's courtyard. Patients reported to us that they were accompanied by clinicians, often more than one. However, they also told us that they had walked from the radiology department and across the courtyard with the frame fitted. When we asked, staff told us this was down to risk assessment, mobility and choice. The lead radiotherapist told us that 'slips, trips and falls' was an area the service focussed on but this was not further elaborated on when we asked and did not appear in risk assessments. Patients were also escorted from their resting bays to the toilet if needed.
- The three point identification check was used in both radiology and radiotherapy as required by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)(2000). IRMER policies were in place. Evidence shown on consent forms, pre assessment questionnaire and nursing forms to show that IRMER 3 point ID check was being conducted.
- Clear signs were in place informing patients and staff about areas where radiation exposure took place. Radiation Protection Supervisors were appointed in each clinical area within the radiology, radiotherapy and nuclear medicine departments and details of medical physics support were available to staff in their local rules.

Nursing staffing

- Treatment appointment slots began at 7.30 and ended at around 4pm. There were typically three treatment days a week. For treatment to take place the service required a physicist, radiographer, treating consultant and a clinical nurse specialist (CNS). If extra staff were needed to maintain patient safety or care, they were transferred over from the provider organisation's nearby acute hospital; this had been done in times of staff sickness or emergency.
- From July 15 to June 16 the provider reported on the numbers of bank and agency registered nurses used to cover shifts. This varied from zero between July and October 2015 and between five and ten shifts covered each month between January and June 2016. Long term sickness of one key member of staff had been covered by regular bank and agency staff. There had been zero unfilled shifts and zero staff turnover.

Medical staffing

- There was a clinical fellow and six treating consultants. There were three fully trained clinical oncologists (consultants with extra qualifications for radiosurgery and Gamma Knife specifically), one fully trained radiologist (Gamma Knife planning trained consultant), two fully trained neuro-surgeons (consultants with extra radiosurgery qualifications), one specialist neuro-oncologist and one clinical fellow.

Good

Medical care

- There were four physicists and a specialist physicist, three radiographers and a bank radiographer. All the physicists and radiographers had been trained by the provider organisation. All consultants and physicists were on professional service level agreements (SLA).
- The centre aimed to train two more physics staff in Gamma Knife planning in the next year. Three full time radiosurgery radiographers rotated between LGK and the provider organisation's nearby acute hospital. Three full time physicists/ dosimetrists able to rotate in and external physics consultant who comes in to plan on Fridays.
- The service operated Monday to Friday; 0730-1600, and out of hours cover was not required.

Emergency awareness and training

- The Environment Agency reviewed safeguards around security and terrorist attack. The most recent was in January 2016 which was dealt with by the chief physicist for the provider organisation. The medical director and radiotherapy lead told us that the centre would be expected to follow the major incident policy of the NHS hospital where they were located and worked in partnership with.
- We saw evidence to show that they had policies and procedures in place for a wide range of major incidents including fire, floods and terrorism.

Are medical care services effective?

Are services effective?

- Effective was inspected but has not been rated. This was because the capturing of patient outcomes was difficult to achieve due to the nature and referral patterns for the service.
- Quality assurance, professional accreditation and benchmarking had taken place.
- Patient treatment eligibility was in line with criteria defined by the NHS commissioning board's clinical commissioning policies.
- There were clearly defined professional roles, with competent staff to fulfil these roles.
- There were good arrangements in place for multidisciplinary working and joint working with the referring NHS hospital.
- There were suitable arrangements in place for gaining patient consent, with opportunities for patients to ask questions about their treatment.
- **Evidence-based care and treatment**
- The standard way for guidelines to be implemented at LGK was through the standards committee of the provider organisation's nearby acute hospital, whose governance arrangements incorporated LGK. This linked to the service managers, who then in turn fed it into their internal governance meetings where the relevant guidelines were implemented and disseminated to staff via local staff meetings.
- Routine audits were conducted and results discussed at local level and through governance structure to ensure actions are implemented and re-audited for effectiveness. NICE guidance was received monthly from the corporate governance team and assessed locally for compliance.
- The service treated patients in line with the Royal College of Radiologists (RCR) publication 'The timely delivery of radiotherapy: standards and guidelines for the management of unscheduled treatment interruptions'. Care and treatment was planned and delivered in line with current standards and nationally/ internationally recognised evidence-based guidance.
- LGK had been involved in the creation of NICE guidelines for Gamma Knife treatment.

Patient outcomes

- Data for the National Radiotherapy Data Set was captured at the time of treatment and submitted to the NHS hospital LGK worked in partnership with on a monthly basis. The National Clinical Analysis and Specialised Applications Team, (NatCanSat) reported back on compliance monthly, via the NHS trust. The nature of Gamma Knife treatment was such that monitoring clinical patient outcomes was difficult to achieve as patients were referred to the service for treatment via an external referring clinician. After treatment the referring clinician monitored the patient's ongoing health. The service was required by the commissioner to contribute data to the national radiotherapy data set and the neurosurgical national

audit programme on the NHS patients it treated as part of the service specifications. The submitted data was amalgamated with data from the NHS trust services the centre was located at.

- Quality management system ISO (9001:2015) and accreditation through evidence based practice by a leading healthcare accreditation authority had been achieved.
- The NHS England SRS/SRT procurement process required the completion of a stereotactic radiosurgery (SRS) and stereotactic radiotherapy (SRT) quality assurance review process in order to benchmark practice. The National Cranial Stereotactic Radiosurgery Dosimetry Audit process was designed to assure NHS England that providers were able to deliver the stereotactic services safely and consistently. In addition, the process ensured standardisation and quality improvement of stereotactic services and promoted consistency and assurance of the quality of SRS/SRT services in England. LGK were one of twenty centres that participated in this audit.
- The audit visit for the National Cranial Stereotactic Radiosurgery Dosimetry Audit took place in April 2016. The aim was to check if the physics staff had calibrated their machine properly and nothing was untoward. Generally the results could be viewed as positive as the tumour received a higher dose of radiation than predicted and the brainstem received a lower dose of radiation than predicted. In a basic test to test the competence of staff and how good their local procedures were, the gamma knife physics staff measured the radiation received to a random point on the body and then the external auditors did the same to the same point. The difference between their results was only 0.7%, which was seen as a smaller than average discrepancy.
- Patient treatment eligibility was in line with criteria for stereotactic radiosurgery (SRS) or stereotactic radiotherapy (SRT) for the treatment of cerebral metastases as defined by the NHS Commissioning board's clinical commissioning policies. Each case was discussed at the multidisciplinary team (MDT), aided by relevant imaging. A pro forma giving eligibility criteria for each condition was completed during the meeting and stored on the patient's electronic record, providing a clear record of eligibility and the MDT decision. A letter communicating the MDT outcome is sent to both referrer and GP.
- The provider told us they regularly attended and present at international meetings including Amsterdam World Gamma Knife, Hamburg European Gamma knife last year, and Montreux 13thInternational Stereotactic Radiosurgery Society in May 2017, which ensured they were conforming to current standards and improving services.
- The provider told us they will be presenting their current research project on tractography, based on 80 patients, at Montreux the 13th International Stereotactic Radiosurgery Society.
- Consultants had published books and papers concerning patient outcomes and we were provided with three examples of this, published in 2002, 2009 and 2015 that were concerned with concepts in neurosurgery, Gamma Knife radiosurgery and acute symptoms after Gamma Knife radiosurgery.
- **Competent staff**
- In 2013 the clinical nurse specialist (CNS) role replaced the RGN role in order to bring more expertise to the role. There was extra learning for specific roles. For instance, the CNS had extra training in anaphylaxis and anticoagulant medication. All staff undertook Basic Life Support training and the CNS was also trained in Immediate Life Support.
- All the physicists and radiographers had been trained by the provider organisation. Radiographers working at the radiotherapy department of The Harley Street Clinic (THSC) were rotated to LGK to gain experience in radiosurgery, develop new skills and promote continual professional development.
- Professional competency assessments were completed once, and on-going competency assessments occurred on a regular basis. We were provided with the assessments for the physicist, nurse and radiographer, which showed a number of professional skills and competencies signed off.
- Physicists could also rotate to learn and develop their planning skills for radiosurgery. Treatment planning in radiotherapy involved a lot of computer simulation and

calculation of doses to ensure the tumour received the appropriate ablative dose while minimising the radiation dose to the normal surrounding tissue. Radiosurgery planning was even more critical due to the higher doses and extreme precision required. There were limited numbers of people with this skill and the department was helping to raise those numbers.

- The provider paid for NHS employed and non-practice privilege holding neuro-surgeons to be sent on the Gamma Knife training programme conducted by the machine manufacturer. This course was financially substantive and was done to provide clinicians a foundation for further career development in this field.
- There were seven doctors employed or practicing under rules and privileges for the provider. There were four physicists and a specialist physicist, three radiographers and a bank radiographer. All consultants and physicists were on professional service level agreements (SLA). All had their registration validated in the reporting period (July 15 to June 16). Practising privileges were processed centrally by provider, with the CEO and medical advisory committee (MAC) providing oversight, with privileges being reviewed annually.
- The MAC reviewed the scope of the individual's workload, and three confidential references from independent colleagues. The MAC may also request additional references. Consultant credentials were reviewed via a report provided to the CEO through the Centralised Credentialing and Registration Service. If there were delays in receiving evidence of up to date documentation, the CEO suspended the privileges accordingly until credentials are provided.
- Medical consultants with practising privileges had their appraisals and revalidation undertaken by the medical director if they did not work at a NHS trust. For those working in a NHS trust a copy of their appraisal and revalidation undertaken at the trust was provided to the hospital.
- There was an annual review of practising privileges, including scope of practice and activity. Any concerns, including competencies, raised about consultants were dealt with through the 'responding to concerns' policy and via the 'decision making group' and then the corporate DMG if required. The provider organisation employed their own responsible officer.
- Performance and practice was continually assessed during mid-year reviews and end of year appraisals. Staff we spoke with confirmed they received regular appraisals.

Multidisciplinary working

- LGK treated 200 patients each year. Each patient was individually cared for by a multi-disciplinary team of professionals to ensure that patient needs were met. The multidisciplinary team consisted of neurosurgeons, clinical oncologists, neuro radiologists, physicists, radiographers and clinical nurse specialists. Referral was through multidisciplinary meetings held at the referring acute NHS hospital, located on the same campus.
- Patients from other NHS trusts were referred Saint Bartholomew's Hospital for treatment at LGK. Many of the specialist clinicians working at LGK did so under practising privileges and also worked at the NHS hospital.
- All patients treated at LGK were first referred to the NHS hospital that LGK worked in partnership with, from their own NHS trust and then referred onto LGK for Gamma Knife treatment. Following treatment they were referred back to the referring trust. 86% of patients were NHS funded. Self funded patients were referred via an acute hospital run by the provider of LGK; HCA International.
- A joint MDT, reviewed earlier this year 2016, met new NHS England radiosurgery contract guidelines. We were told that the working relationship between the centre and the NHS hospital had improved since the introduction of the new MDT meeting.
- Multidisciplinary team meetings were attended by the entire LGK team as well as the NHS Hospital's team of physicist, clinical fellow, radiographer and neuro radiologist. Oncology patients and specifically radiotherapy patients were discussed as to whether to use Gamma Knife or the NHS trust owned Cyberknife.
- There was also a MDT meeting held at the NHS hospital that LGK attended. All patients were reviewed by the MDT before being accepted for treatment. The multidisciplinary team (MDT) initially assessed patients against eligibility criteria based on the number and volume of lesions, brain metastases and a life expectancy of greater than six months.

Good

Medical care

- Due to patients needing to be planned prior to being treated the patient must first have a MRI scan. The scanner was owned by the NHS radiology department and was performed before the NHS hospital's opening hours or additional time was negotiated between the department leads. A NHS employed radiologist reviewed all the MRI scans for LGK and were used as a liaison between the centre and the radiology department. LGK had provided the funding for the required consultant training to check the scans. A LGK radiographer and CNS were always present to assist and tend to the patient care needs.

Access to information

- The outcome of MDT assessments and assessment meetings may be to decide to request more information such as MRSA states, bloods taken or whether it was relevant to report these. MRI scans might be requested or decide to repeat that information. All patients treated at LGK were first referred to the NHS hospital that LGK worked in partnership with, from their own NHS trust. This made it vital for good access to information to be in place. The non clinical manager told us they had access to the NHS' electronic patient record (EPR) system, which enabled them to be able to retrieve the records of patients that had been referred. Medical history information was gathered prior to the referral criteria meeting, which was the first MDT meeting to discuss accepting any referred patient.
- The superintendent radiographer and the physics teams had a NHS.net account to aid in the swift transfer of data between the two teams, as access to data was strictly controlled for staff not employed by the NHS. The email address had been created that could be accessed by the general manager for oncology, pathway managers and oncology registrars at the NHS hospital, as well as the pathway manager at LGK. This meant there was a better sharing and flow of information between all members of the multidisciplinary treatment teams. It also meant that registrars working under the consultants who treated at LGK, had access to patient information when newly rotated.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients consented at the pre-assessment clinic and by the consultant in charge of their gamma knife treatment. The consent form was not signed until the morning of the treatment day.
- Patients were given written information about the treatment, disease at the pre-assessment clinic by the CNS and were given the opportunity to discuss any worries and concerns.
- The treatment radiographers phoned the patient in the week prior to their treatment and confirmed their booking details such as name, date of birth and, treatment site. They also reiterated the treatment details and the possible side-effects and gave the patient an opportunity to discuss any concerns.
- The nature of Gamma Knife treatment was that someone will often accompany the patient and stay with them. We were told that the CNS would be expected to pick up any capacity issues and any other issues relating to the patient's capacity such as with dementia at the pre assessment stage.

Are medical care services caring?

Outstanding ☆

We rated caring as outstanding because:

- Patients told us that undergoing Gamma Knife treatment could be an anxious time and that staff took in to account that people may be nervous and helped them manage this through their supportive approach. Patients told us this made a significant difference to their overall experience of the service.
- Staff took the time to explain treatment to patients. Patients felt involved in their own treatment and decisions regarding their treatment. Family members and friends who accompanied patients also felt included.
- The service was caring and compassionate in its approach.

Compassionate care

Good

Medical care

- All staff we spoke with stressed that patient care and experience was paramount to LGK and the provider organisation and that all patients were treated with the same high level of care regardless whether private or NHS.
- We spoke with eight patients who had completed both treatment and follow up at the service. Everyone told us that staff were very caring. Patients told us: "It was a very good service. The way I was treated was all brilliant." "Amazing service, down to the physician working out what was needed. The MDT were all there taking an interest in it. They really put me at ease, they were very skilled." "Really pleased how it all went. Care, communication was great. All in all I couldn't have asked for more."
- Data for the Friends and Family Test in the reporting period (July 15 to June 16) showed a response rate of 26% for all patients and achieved a score of 94% for all patients in the last month of the reporting period. Friends and Family Test data was assessed quarterly. Results were reviewed by service leads and team. All feedback was reviewed by service leads and at governance and MAC meetings and fed back to teams. We were told that if a response was requested by the patient, this was provided.
- The provider told us that patient feedback surveys were given to all patients following treatment, who were encouraged to complete them. Surveys were given to all patients and had recently started offering email communications to patients as a result of feedback.

Understanding and involvement of patients and those close to them

- We spoke with eight patients who had completed both treatment and follow up at the service. Everyone we spoke with told us they, and their relatives, felt involved in treatment because staff of all disciplines listened to them, kept them informed about treatment and included them in decisions about their care.
- Patients told us: "we received information beforehand and (the treating consultant) talked us through it. A nurse talked us through the treatment." "From the time I got there everyone explained everything to me." "They also kept my sister informed and involved her." "They definitely made my husband feel included." "My husband was made to feel included and kept in the loop." "They explained everything as it went along." "No one was too busy to talk to you and explain things."

Emotional support

- Patients had access to the counselling service, complimentary therapies and Macmillan centre if needed which was based at THSC.
- Patients told us that undergoing Gamma Knife treatment could be an anxious time, however staff took in to account that people may be nervous and helped them manage this through their supportive approach. "I was a bit nervous. They reassured me and told me if I needed to I could be pulled out and for a pause and it wouldn't be a problem." Another told us "I am not the bravest of people and they were very understanding". "I had a tickly cough as I had the frame fitted. The nurse got me a drink of water straight away, the (treating consultant) said it was okay and explained things to me regarding this."
- Patients were also offered music or religious recitations during the treatment, staff could also speak to them through a microphone.

Are medical care services responsive?

Good

We rated responsive as good because:

- There was an increase in demand for the service and The London Gamma Knife Centre at Barts (LGK) had taken appropriate steps to respond to this as well as introduce measures that enabled the best use of treatment time.
- Patients with malignant tumours received timely treatment. The service aimed to treat patients within 14 days. Referral to treatment averaged at around 9 days.
- Patients and referring services received prompt treatment summaries.
- Treatment was planned and delivered in ways that met people's needs and the service listened to patients' preferences and accommodated these.

- Assessments identified people's individual needs, which were being met.
- There were systems in place to effectively respond to concerns and complaints.

However:

- Although the service triaged patients appropriately there was delayed access to treatment for benign patients.

Service planning and delivery to meet the needs of local people

- A new NHS contract had meant there was an increase in demand for the service and was considering moving to another location, which was currently being discussed, which may be a bigger facility within the NHS hospital's complex or relocation. The service was also looking at making it possible for the clinical research fellow to be permitted to treat. They were looking to resource the amount of support staff needed for this, thus increasing the number of treatment days per week, hoping to begin treating acoustic patients in early 2017.
- Over time and use, the machine's potency diminishes meaning treatment time needs to be extended. An upgrade of the Gamma Knife machine was part of the medium term plan in order to decrease the length of treatment and to keep up with patient demand. A new machine would allow for fractionated treatment with the use of an attached CT scanner to the machine, which would allow treatment of patients that were intolerant to the stereotactic frame.
- One outcome of the pre assessment process audit, carried out 18 months ago, was that people preferred not to come in person for a pre assessment. Some patients travelled from outside of London, sometimes a distance away and had serious conditions so unnecessary travel meant telephone assessments were preferred.
- Patients were also called a week prior to the treatment by the lead radiographer to discuss the treatment, and answer any queries or concerns to ensure a smooth patient journey.
- We spoke with eight patients who had completed both treatment and follow up at the service. Patients told us they were well informed by the information sent to them beforehand. We were told: "They sent me a brochure about what to expect. It included pre-treatment, post treatment, everything was explained. It happened according to the information too." "I was sent a big leaflet including details of the machine." "I was given a booklet well beforehand. I could phone them if I had any questions."

Meeting people's individual needs

- We were told that the CNS would be expected to pick up any individual needs and any other issues relating to the patient's vulnerability such as dementia at the pre assessment stage. Patients were referred from a large geographical area that included most of southern and eastern England. Pre assessment could be completed by telephone to save people a journey, or in person if patients were local and preferred this.
- The pre assessment forms showed the pro forma covered presenting conditions, past medical history, kidney problems, alcohol intake and vital signs. There was identification of specific issues to be addressed such as whether the patient was able to lie flat or whether they were claustrophobic as treatment for Gamma Knife and MRI meant lying flat and being in an enclosed space. If patients were overly nervous or anxious, lorazepam could be prescribed. Another example of pre assessment was given where a patient ate non solid food and suffered from a number of conditions such as angina, osteoporosis and arthritis. Another that had hypothyroidism, asthma and hypertension.
- There was no signage directing people to the service. The only sign we saw was at the door to reception which was well within the basement area. Patients reported to us that they were instructed to report to the NHS hospital's MRI reception in their introduction letter. Following MRI and/or having the head frame for Gamma Knife treatment, they were escorted by the clinician over to the service's premises. The frame fitting area was located next to the MRI scanner. There was a recovery room that was shared. If people came for a second appointment they were met by staff at ground level and escorted down.
- Patients were offered appointments by phone. If there was no response after three attempts, they were written to. Both transport and accommodation needs were discussed in this contact. If there was an identified transport need the telephone number of patient

transport services for the NHS hospital that LGK worked in partnership with were given, as patients were required to book this in person where eligibility questions are asked. We spoke with eight patients who had completed both treatment and follow up at the service and asked them if they had been offered transport. Some could not recall whether they had, but had their own transport anyway, while others told us that on the original letter there was an offer of transport, or that they were asked whether they were mobile.

- With accommodation, the NHS hospital that LGK worked in partnership with had its own patient accommodation that patients were able to access, located nearby. This was free of charge and you were able to bring another person with you. If there was no space, accommodation was available at another NHS hospital location. We were told this had only had to be used a couple of times in a number of years.
- Patients living with learning disabilities, dementia or who had mental health issues, who had the capacity to consent and tolerate the treatment process were always accompanied by the clinical nurses specialist (CNS) throughout their pathway. We were told that patients with learning disabilities, dementia, or mental health issues were very rare and would not routinely be accepted as the process of treatment involved being fitted with a head frame and going in to a confined space which may increase anxiety, this would usually require the use of general anaesthesia which the centre was not equipped for.
- We were given an example where treatment was delayed in order to access the translation service. The policy was not to rely on relatives or friends for this, but to organise face to face translation services, which were sourced through the NHS trust's translation services. Access to the provider's language line was also available if this was deemed appropriate.
- Multi-faith prayer room was available in the NHS hospital. However, patients were usually provided with a prayer mat and could use the side room if they wished. Written information was readily available in Arabic only, however braille, audio loop and other languages could be sourced in advance. There was no provision for bariatric patients as they were deemed unsuitable for treatment.
- We spoke with eight patients who had completed both treatment and follow up at the service. People told us they felt their individual needs had been taken in to account. We were told: "Yes, they are very good. They accommodated us because we had a holiday booked, so they changed our appointment time and gave us a post treatment phone call instead of going in for an appointment." "I called to ask them to check hotels for us. We were advised well. I wanted to be away from the hospital but not too far." "I spoke to (the treating consultant) a few times since. They are keeping me informed. I have spoken to him four times now in four weeks, all arranged." "I got a copy of the letter handing me back over to my local trust. I also had a phone call from them asking me if I felt okay. It was one of the nurses I met on the day."

Access and flow

- We were told by the treating consultants that a Gamma Knife plan can take between 40 minutes to 2 hours to plan, including the time the consultant takes to delineate the target volume, the physicist to plan the treatment and the plan to be second checked by a physicist at the radiotherapy and medical physics department in THSC.
- Patients reported to us that they were instructed to first report, at 07.30, to the NHS hospital's radiology reception in their introduction letter. Due to patients needing to be planned prior to treatment, the patient first had a MRI scan which was owned by the NHS hospital's radiology department, and was performed before the NHS hospital's opening hours. Additional time was sometimes negotiated between the department leads. The scan was performed by the NHS radiographers with the radiographer and CNS from LGK present to assist and tend to the patient care needs.
- The head frame needed for Gamma Knife treatment needed to be fitted, which also took place in the NHS hospital's radiology department. The consultant fitting the frame was present until the patient was taken back to the site of the treatment provided by LGK.
- Patients were then escorted by the clinician over to the service's own premises. This involved going from the basement to ground floor, across the NHS hospital's courtyard and down to the basement where the service was located. Access was via a patient lift or stairs from the ground floor. There was no signposting to direct

people to the service. The only signage was at the door to reception. If people came for a second appointment they were met by staff at ground level and escorted down.

- We asked patients who had used the service about their experiences of this system. One person told us they had visited three times and were met at the door each time. Others told us they were met at the main hospital's reception area and others at the NHS radiology department. Patients told us they were always escorted across to the location of LGK.
- Others told us that they travelled from outside of London, sometimes a distance away, so the 07.30 start time meant that overnight accommodation had to be sourced in order to make the appointment.
- There were two patients on the day of our unannounced inspection. One was just returned following an angiogram and was waiting in the unit. The other had just had their frame fitted and was being escorted over.
- Once patients had been escorted over, they waited to be treated and rested in one of the three bays. Tea and coffee, food such as fruit, sandwiches, snacks and desserts were offered and provided. Patients were also provided complimentary Wi-Fi access and there were also computer tablets, newspapers and magazines.
- We asked patients who had used the service about their experiences of this system. We were told: "we were offered coffee and biscuits. (A member of staff), bless her, went and bought me a sandwich." "The consultant wasn't there and pre-treatment was done by the consultant's team. This was the only thing, the waiting." "They tried everything to make us comfortable but here was a lot of waiting. We were told two to three hours but it took seven or eight. My parking cost £20."
- Frame removal was done by the CNS in order to speed up the process, which saved time for the patient and did not require the presence of the consultant.
- Patients occasionally needed admitting overnight which could occur when patients were treated for blood vessel malformations or if a patient felt unwell post treatment. It was the service's policy to pre-book beds and to cancel them later if not needed. NHS patients were transferred to the NHS hospital's oncology ward and private patients are transferred to a private hospital via private ambulance. In the reporting period, July 2015 to June 2016, the service reported 100 bed days.
- Patients were first referred into the care of the NHS hospital. Patients were then referred to LGK for Gamma Knife treatment and follow up. Patients were then discharged back into the care of the NHS trust, who discharged them back to their referring authority.
- A summary of treatment was completed on the day of treatment, which went to the NHS hospital, the referring authority, the patient and GP. This was recorded contemporaneously and given to patients as they left the service. It contained details of treatment given, doses of radiation, and any risk issues identified in the assessment process. Patients we spoke with told us they had received a copy of their record of treatment.
- We were provided with a treatment log that showed the length of time from referral at the MDT meeting, to treatment for the period of time from 01 January to 30 November 2016. 135 Patients were treated. It showed that 94% of patients with metastasis, which was malignant, were treated within 31 days. Referral to treatment ranged from zero days to 42, averaging at around 9 days. The service aimed to treat patients within 14 days. Four were above the 31 days, with one outlier at 177 days. We were told that the delay was due to patient choice and 3 due to clinical reasons.
- 77 patients with benign tumours were treated within the range of 4 to 284 days, with an average of 81 days. We were told that 10 patients with benign tumours chose their appointment dates to be delayed and all others were booked in accordance to patient choice and clinical pathway scheduling.
- We were told that a new NHS contract meant that patients were now treated for up to 20 lesions whereas before it would have been two or three, which meant that benign patients were pushed down the order of priority and patients ended up waiting a little longer. To mitigate against this, short notice (one to three days) appointments were now offered to patients who were happy with this. Referral pathways had been worked on to assist the flow and assist with accessing relevant

information. Medical advisory committee minutes from October and November 2016 were provided which showed analysis and discussion around scheduling and machine usage.

- An excel document called 'waiting list- a working document' was viewed on site. It contained all the names of patients that consultants were due to treat and those they wished to discuss at MDT, as well as others, including prospective referrals. It also showed when patients had been treated.
- The treatment log documented when patients were referred and treated. At the time of our inspection there were a total of 98 patients on the waiting list. Of this 51 patients were ready to be scheduled; 50 patients with benign tumours. There were 37 patients, which required further clinical information before they could be scheduled and four patients with funding requests underway.
- In the reporting period (July 15 to June 16) no procedures were cancelled for a non-clinical reason.
- Patients were now offered the option of follow up appointments in person or by telephone. Patients were referred from a large geographical area which meant that travel time outweighed the benefit of being there in person in most cases. Patients told us they had received follow up by phone and had sometimes been in contact with the consultant more than once a week. One patient told us they had waited two hours for a follow up appointment that lasted two minutes. The medical director told us the follow-up rate for patients in person was approximately 50%, which was below what they would like. The reason stated for this was due to the patient demographic coming from a wide geographical area and not attending in person. The service was copied in to all correspondence of further follow-ups and diagnostic testing conducted post treatment by other the referring consultant or GP. In information provided to us by the provider prior to our visit, we were told that NHS patients were further followed through their relevant NHS outpatient clinics and that private patients were invited back for follow up after treatment.

Learning from complaints and concerns

- In the reporting period (July 15 to June 16) the provider received zero complaints.
- The agreed timelines for responses to formal complaints was that an acknowledgement letter was sent within two working days and a full response letter sent within 20 working days. If an investigation could not be completed within this period, the complainant was written to informing them of the delay and provided with the date that the complaint response will be provided.
- For shared learning, LGK were included within the governance structure of the provider company's nearby acute hospital, who measured response rates to complaints. The overall performance for all formal complaints in 2015 was 99% for acknowledgement within 2 working days and 90% for a full response letter within 20 working days.
- Any complaint received was acknowledged and logged on the online incident reporting system, then passed to the appropriate manager to investigate, who was also responsible for sharing the learning from individual complaints. The governance team supported the complaints investigation process by ensuring that due process was followed and developing any action plan that may be required from investigation.
- All complaints and concerns were received by the CEO and discussed at the point of acknowledgement. Complaints were also raised with the medical director and/or MAC chair where appropriate.
- Staff aimed to resolve concerns immediately if possible, and inform their manager of the concerns raised. A complaints leaflet was available which described the process should a patient want to raise a concern. There was also the ability for people to provide feedback on the hospital website. If the manager informed feels the complaint may be serious, or had been unable to resolve the concerns raised, they escalate the concern to the CEO or chief nursing officer.
- All concerns raised were formally recorded and, depending on the outcome following the meeting with the complainant, the concern classified as either informal or formal. Should the complainant wish to make their complaint formal, they received a written acknowledgement letter that included the complaints leaflet. If the complaint remained informal it was raised with the service manager who contacted the patient about the action taken and learning.

Good

Medical care

Are medical care services well-led?

Good

We rated well led as good because:

- There was operational, clinical and non clinical leadership and clear lines of accountability within the service**.** There was a visible leadership presence and regular rounding by the executive.
- The London Gamma Knife Centre at Barts (LGK) was a small service that had been incorporated into the governance and oversight structures of a nearby acute hospital that also provided radiosurgical services, and belonged to the same provider company, HCA International. We were satisfied that the LGK voice, and issues pertinent to the service benefitted from this arrangement.
- There was also a meeting structure that was exclusive to LGK, with accountability and assurance that fed in to the larger structure.
- There was a clear vision, strategy and improvement plan. Innovation incorporated working with demand and delivering a quality service.

Leadership and culture of service

- The lead therapy radiographer was the day to day operational lead for the service and reported to the radiosurgery service manager, who in turn reported to the chief executive (CEO) for LGK and THSC.
- LGK was a small service and drew on the benefits of being held within the governance structure of the larger hospital. There were a number of leads including for infection control and safeguarding, who were based at this nearby hospital which meant a more resourceful leadership. The medical director had oversight of all LGK patients and was line managed by the chief medical officer for the provider. LGK were well integrated in this structure. Staff rotated regularly, and there were no isolation concerns.
- There was a visible leadership team and regular rounding by the executive and leadership teams took place. Open forums and sessions reinforced the vision and values of the organisation. Staff surveys supported open understanding of culture, transparency and staff engagement.

Vision and strategy for this this core service

- In February 2016 a management away day looked at priorities and strategies for the year ahead. Patient pathways and patient experience were the focus in order to drive the quality of service.
- The non clinical manager, clinical fellow and CNS all worked solely at LGK which was a small service. The CEO also worked at THSC, and told us one of their ongoing strategies was to not isolate the LGK team and incorporate them in to a wider team structure and for the service itself to feel like part of a larger governance structure. Staff told us they did not feel isolated as they regularly rotated back and forth between the two sites.
- Senior managers explained that there were plans underway to further integrate the oncology pathways with THSC, with the longer term goals to create a cancer network across all of the provider's services, thus allowing services to work more closely together. The reasoning behind this strategic development was to provide a seamless consistent level of care for patients using the service.
- The chief executive (CEO) told us the aim of the service was 'every patient every time', and that 'project world-class' was a scheme rolled out across all of the provider's facilities. This was a course designed to complement and enhance patient skills, bedside manner and general customer service for all employees. All fully employed staff were welcome to join. The course was run by employees of top tier hotels to pass down their customer service skills.
- Information provided to us prior to our announced visit showed that the vision and strategy aimed to 'grow and diversify our business considering new ideas, initiatives and ways of working: having an eye for detail - every patient, every time and to look after the needs of our patients, their families, our staff and colleagues and our consultants.' Also, that the service recognised and valued everyone as a unique individual and treated people with kindness and compassion with honesty, integrity and fairness.

- The delivery against the strategy was monitored at the chief executive's meeting. The vision was devised during planned workshops, with three options passed to the executive team for consideration. The cascade of the final vision and strategy includes a clear communication campaign, drop in sessions, full relaunch and presentation in staff areas.

Governance, risk management and quality measurement

- There was a well established governance framework in place which incorporated LGK in to the structure of one of the provider organisation's larger hospitals, which was located nearby. LGK, being a small service, was held within this governance structure which served many functions.
- We asked the chief executive how they could be confident that, as a smaller service, it did not get swallowed by the larger hospital's business and day to day issues. We were told that LGK were very much part of the overall picture and their presence at meetings was prominent enough to be able to benefit from this structure. Minutes from joint MAC and operational meetings demonstrated that the LGK issues were discussed at these forums.
- There was an on site operational meeting that took place every two months at LGK which was the primary governance and management meeting for the service. It was chaired by the lead radiotherapist who provided on site operational leadership and was attended by the CEO, medical director, CNS, and research fellow. The CEO also met separately with the lead radiotherapist and the medical director every month.
- The LGK medical advisory committee took place on a quarterly basis.
- There was a joint radiosurgery division within this governance structure. The lead radiotherapist for LGK attended monthly radiation protection meetings and was represented at radiation oncology board meetings. Radiotherapy radiation protection meetings discussed all radiotherapy related radiation safety, learning, training, incidents and other issues and fed in to the wider governance structure and in to the corporate radiation protection committee which dealt with all radiation protection issues.
- There was a joint corporate governance meeting which was attended by key LGK staff as well as a joint operational meeting to which LGK were represented.
- All meetings fed in to the chief executives' council, which met quarterly and was attended by all senior managers. There was a quality and safety group was also attended by all CEOs.

Public and staff engagement

- A monthly update was sent to all staff on a quarterly basis and all staff were invited to the quarterly update that took place at THSC. The CEO told us this was well attended by LGK staff. In information provided to us by the provider prior to our unannounced inspection, we were told that the strategy to engage staff included open forums with the executive management team, presence of the CEO at quarterly unit operational meetings, newsletters for both staff and consultants and regular updates.
- For shared learning, LGK were included within the governance structure of the provider company's nearby acute hospital where there were weekly patient experience and satisfaction meetings chaired by the chief nursing officer and attended by the managers of clinical and non-clinical services, which supported the investigation process of a complaint and also on following up any actions and learning. Managers of clinical areas that received compliments or cards were able to share them at this forum. Compliments that were sent through to the executive office were recognised by the CEO with the named departments and individuals praised. An overview of complaint themes was also presented to the MAC.

Innovation, improvement and sustainability

- The chief executive told us they were always looking to share their knowledge and research and strived to be published and renowned for the service they provide. There was a research workstream that reported to the board.
- LGK held symposiums annually. The symposium was paid and catered for by the provider organisation. The 2015 programme demonstrated that oncologists, neurosurgeons, nurses, radiographers and physics staff

from the UK and overseas were invited to attend and participate. This year the symposium was not held due to organisational changes but was planned to be held again in 2017.

- The service had responded to the increase in demand the service was considering relocation.
- The machine used a cobalt source to produce radiation for treatment and the age of the source was increasing which subsequently resulted in longer treatment times for patients. Management at the NHS trust that LGK worked in partnership with had changed in 2014 which led to a reported better relationship with their leadership team who stated their commitment to LGK remaining on their campus, which influenced the decision to replace the cobalt 60 sources. However, the national decision in 2015 to review the provision of NHS intracranial radiosurgery in England had led to a national redistribution of referrals. An upgrade of the Gamma Knife machine remained part of the medium term plan in order to decrease the length of treatment time and to keep up with patient demand. A new machine would allow for fractionated treatment with the use of an attached CT scanner to the machine, which would allow treatment of patients that were intolerant to the stereotactic frame.
- Frame removal was done by the CNS which was innovative practice and saved time for the patient and did not require the presence of the consultant.

Outstanding practice and areas for improvement

Outstanding practice

Patients told us that undergoing Gamma Knife treatment could be an anxious time and that staff took in to account that people may be nervous and helped them manage this through their supportive, caring and compassionate approach. Patients told us this made a significant difference to their overall experience of the service.

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure that:

- Staff have a working knowledge of when it might be appropriate to escalate potential safeguarding issues.
- Training levels were below the already low 'green' rating of 81%. The provider should assure itself that training attendance is at an acceptable level and issues from recording training in the new system are resolved.
- Patients are formally risk assessed to be able to choose to walk, accompanied, back to the service once the stereotactic head frame had been fitted.