

The Christie NHS Foundation Trust

The Christie Main Site

Quality Report

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

Ratings

Overall rating for this hospital		Outstanding	☆
Medical care		Outstanding	☆
Surgery		Outstanding	☆
Critical care		Good	●
End of life care		Outstanding	☆
Outpatients and diagnostic imaging		Good	●
Chemotherapy		Outstanding	☆
Radiotherapy		Outstanding	☆

Summary of findings

Letter from the Chief Inspector of Hospitals

The Christie NHS Foundation Trust is a 188 bed (including critical care) comprehensive cancer centre serving a population of 3.2million people across Greater Manchester and Cheshire, with 26% of patients being referred to us from across the UK.

NHS activity is commissioned by the specialist commissioners of NHS England with over 90% of activity being ambulatory care. There is an annual turnover of £230 million, operating with 2,500 staff, 350 volunteers, 27,500 public members and have one of the largest hospital charities.

The Christie NHS Foundation Trust has one of the largest clinical trials portfolios and are part of Manchester Cancer Research Centre working in partnership with the University of Manchester and Cancer Research UK. They are also one of seven partners in the Manchester Academic Health Science Centre.

The Networked Services division provides clinical and medical oncology services across Greater Manchester & Cheshire, clinical haematology and transplantation, teenage and young adult services and specialist endocrinology. The clinical and medical oncology services include the delivery of radiotherapy on the Withington site and at two satellite centres at local provider sites. The Cancer Centre Services Division includes surgery (including anaesthetics and theatres), the surgical day case unit, critical care, oncology assessment unit and outpatients and diagnostics.

There are currently 13 service linear accelerators providing service radiotherapy treatment, which includes external beam, brachytherapy, image guided radiotherapy and stereotactic radiotherapy. Chemotherapy treatment is delivered on the Withington site and through 9 outreach sites and a mobile unit across Greater Manchester and Cheshire. At the Withington site there are 50 chemotherapy treatment chairs and beds providing up to 135 treatments per day. The Christie Medical Physics and Engineering division provides expertise, local and national in medical physics which includes PET-CT scanning and nuclear medicine.

We visited the Christie main site, Oldham and Salford as part of our announced inspection during 10 to 13 May 2016 March 2016. We also carried out an unannounced inspection on 25 May 2016. During this inspection, the team inspected the following core services:

- Medical care services
- Surgery
- Critical care
- End of life
- Outpatients and diagnostic services
- Chemotherapy
- Radiotherapy
- Our key findings were as follows:

Leadership and management

The hospital was led and managed by a visible executive team. This team were well known to staff, and staff spoke highly of the commitment by leaders to continually improve services putting patients and people close to them at the centre of decision making.

Staff felt involved in decision making, and felt that they were able to influence the vision and strategy of The Christie NHS Foundation Trust.

Summary of findings

There was effective teamwork and clearly visible leadership within the services.

Both trust and local leadership sought continuous improvement and innovation and research in both services and procedures they delivered. There was significant involvement in research and clinical trials programmes in order to improve the care and treatment provided for patients.

The NHS staff survey 2015 showed the trust performed better than the national average for 11 indicators. The overall staff engagement score for the trust was 4.03, which was better than the national average score of 4.01 for specialist acute trusts.

Access and flow

- There was a 24-hour telephone helpline service (hotline) for patients and carers for advice on the side effects and complications of cancer treatments, such as chemotherapy. Advice was given by nurse practitioners with consultant and registrar support if needed.
- The oncology assessment unit (OAU) had 20 inpatient beds and rapid access clinic beds (open Monday to Friday) to accommodate urgent and unplanned medical and surgical admissions to the hospital.
- Patients could be admitted to the OAU directly following an outpatient appointment, via the 24-hour hotline service or transferred from other hospitals. Patients requiring admission to the hospital were transferred to the hospital wards from the OAU.
- Records between April 2015 and March 2016 showed average bed occupancy rates were; OAU (80%), ward 4 (91%), ward 11 (93%), ward 12 (91%) and Palatine ward (90%). Bed occupancy rates varied across the medical wards.
- We did not see significant numbers of medical patients admitted to the surgical wards (medical outliers) during the inspection. We identified two medical patients that were located in the surgical wards. There were instances where medical patients were placed in other medical specialty wards due to capacity issues. However, the numbers we observed were not significant. For example, the lead nurse on the Palatine ward told us there had been six patients placed on wards 11 and 12 during the past week due to bed availability issues.
- Records between February 2015 and January 2016 showed 7,734 patients (95.3%) did not move wards during their hospital stay and 382 (4.6%) had one or more ward moves following their admission. The overall number of patients that had one or more ward moves during their admission (382) had improved from 493 during the previous 12 months. Ward staff told us they avoided moving patients once admitted and one of the main reasons for bed moves was ward refurbishment activities.
- The rate of delayed discharges based on the proportion of occupied bed days per month ranged between 0.3% and 1.8% from April 2015 to March 2016. This showed the majority of patients were discharged from the medical wards in a timely manner.
- The referral to treatment (RTT) incomplete pathway standard is that at least 92% of patients should have to wait less than or equal to 18 weeks of referral for their treatment. Hospital records showed compliance against the incomplete pathway standard was 98.5% between April 2015 and March 2016 (i.e. 2015/16).
- In June 2015, NHS England abolished the RTT standard that at least 90% of admitted and non-admitted patients should start treatment within 18 weeks of their referral. Records showed the hospital achieved 98.6% compliance for non-admitted patients and 96% compliance for admitted patients during 2015/16.
- The NHS 31-day cancer waiting time standard is for at least 96% of patients who are newly diagnosed with a cancer to receive their first treatment within 31 calendar days from the date of the decision to treat. Hospital records showed compliance against the 31-day standard was 98.4% during 2015/16.

Summary of findings

- During this period, the hospital achieved 99.8% compliance against the standard for at least 98% patients to experience a maximum wait of 31 days for a second or subsequent anti-cancer drug treatment.
- The NHS 62-day cancer waiting time standard is for at least 85% of patients who are urgently referred by their GP with a suspicion of cancer and are subsequently diagnosed with cancer should wait no longer than 62 calendar days from the date the referral is received by the hospital to the date of their first treatment. Records showed compliance against the 62-day standard was 88.5% during 2015/16.
- During this period, the hospital achieved 88.0% compliance against the standard for at least 80% patients to experience a maximum wait of 62 days
- The hospital also achieved 97.6% compliance against the standard for at least 90% patients to experience a maximum wait of 62 days for first treatment following referral from an NHS cancer screening service during 2015/16.
- 99% patients were seen within 24 hours of being referred to the specialist palliative care team.

Cleanliness and infection control

- Clinical areas at the point of care were visibly clean.
- The trust had infection prevention and control policies in place, which were accessible to staff and staff were knowledgeable on preventing infection and minimising risks to patients, visitors and staff.
- There was enough personal protective equipment available, which was accessible for staff and staff used this appropriately, however we observed that local policy related to insertion of invasive lines and personal protective equipment was not always followed.
- Staff generally followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures.
- There had been no MRSA bacteraemia infections and 17 Clostridium difficile (C.diff) infections relating to the hospital between April 2015 and March 2016. Of the 17 infections, all were classed as 'unavoidable' which meant they were not caused as a direct result of lapses in the care provided by the hospital.

Staffing

- Nurse staffing was calculated, reviewed and audited bi-annually using a recognised patient acuity and dependency tool the 'safer nursing care tool' (SNCT).
- The matrons and ward managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. The ward managers told us staffing levels were based on the dependency of patients and this was reviewed daily.
- The wards we inspected had sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- Records showed the average shift fill rates for nursing and care staff on the medical wards were consistently above 95% between January 2016 and April 2016.
- The nursing staff were supported by a number of advanced nurse practitioners (ANP's) that worked across the medical services. For example, there were five ANP's covering the oncology assessment unit (OAU).

Summary of findings

- The proportion of consultants and registrars across the medical services at the hospital was greater than the England average. The proportion of middle career doctors was below the England average (4% compared with the England average of 6%). The proportion of junior doctors was also below the England average (1% compared with the England average of 22%).
- There were separate medical rotas in place to cover specific specialties, such as head and neck and gastroenterology, chest and gynaecology, and urology, lymphoma and melanoma.
- There was sufficient on-site and on-call consultant cover over a 24-hour period including cover outside of normal working hours and at weekends. The on-call consultants were free from other
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs.
- Whilst radiography staffing was good at Salford and Oldham radiotherapy services, staffing at the Christie site on the treatment floor was challenging and staff were working additional hours on a daily basis to ensure that all patients received their treatment and morale was low. Radiography staffing in other areas of the department was better. There were also problems with staffing on the reception areas, however the newly appointed manager of the service was aware of all the staffing issues and plans were in place to review departmental needs.

Mortality rates

- The overall five-year survival rate for patients diagnosed with showed significant improvements for the majority of patients between 2005 and 2015.
- The overall survival rate for patients with brain and central nervous system (CNS) tumours varied by tumour type with patients with glioblastoma (GBM) showing the worst outcomes. GBM is the most common and aggressive primary malignant brain tumour in adults. A report from July 2015 showed the rate for patients with GBM was 27.4%, which was comparable to the England average of 28.4%.
- The head and neck cancer report from February 2015 showed one year survival from diagnosis for cancer of the larynx among patients who received their first treatment at the hospital was 88%, which was better than the estimated England average of 85%.
- One year survival for prostate cancer for all patients receiving primary treatment at the hospital was approximately 98%, compared to the estimated England average of 93.6%.
- Audit reports from 2015 and 2016 showed the overall survival rates for patients with skin melanomas; Hodgkin lymphoma and cancer of the bladder were also comparable to estimated England averages based on Cancer Research UK data.
- The Christie stem cell transplant programme annual report for 2015 had not yet been published. Data from the 2014 annual report showed one-year survival rates for autologous (and allogeneic (other person's marrow or stem cells) transplants remained largely unchanged over the last decade. The one year survival rates were also equivalent or better than national figures from the British Society of Blood and Marrow Transplantation (BSBMT) 2013 report.
- The trusts major surgery 30 day survival rate from 1 January 2015 to 31 December 2015 was 100%.
- The national bowel cancer audit (2015) showed the trust performed better than the England average for adjusted 90 day mortality, adjusted two year mortality, adjusted 90 day readmission rates and data

Summary of findings

completeness; this is despite Christie patients being recorded as having more distant metastases. The Christie undertook less laparoscopic procedures 46% against an England average of 57% and 77% of Christie patients stayed in hospital longer than five days in comparison to 69% on average across England. The Christie excised 14 lymph nodes on average against an England average of 17.

Nutrition and hydration

- Patient records included assessments of patients' nutritional requirements. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients did not eat enough, this was addressed by medical staff to ensure patient safety and comfort. Patient records also showed that there was regular dietician involvement with patients who were identified as being at risk.
- Patients with difficulties eating and drinking were placed on special diets or provided with 'finger foods' to facilitate their eating. We also saw that the wards used a 'red tray' system so patients living with dementia could be identified and supported by staff during mealtimes.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.
- Wards had access to a dietician with core hours who provided advice and input for those people who were highlighted to be at risk of dehydration or malnutrition. We saw evidence that this process was followed.
- The nutritional requirements of individual patients were highlighted during handovers, ward rounds and multi-disciplinary meetings to ensure a holistic approach to care. Those who were on fluid or food charts and those who needed assistance or encouragement with eating and drinking could be highlighted by notes above their bed.
- Wards had access to a diabetes specialist nurse who was available for advice for patients and staff.
- Patients told us they were happy with the quality and choice of food and that was provided.
- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- A nutritional screening tool was used to assess the needs of the patient.

We saw several areas of outstanding practice including:

Medical care services

- The availability and accessibility of services for patients and their relatives, such as the complimentary therapies, food voucher service and were identified as outstanding practice.
- The trust was named, by the National Institute for Health Research (NIHR), as one of the best hospitals providing opportunities for patients to take part in clinical research studies. The Christie School of Oncology was established to provide undergraduate education, clinical professional and medical education and this was one of the first its kind nationally.

Surgical services

- The surgical division demonstrated an outstanding approach to treatment by the multidisciplinary cancer team who offered bespoke multi-speciality treatments, together with multi-modality therapy to patients, which improved survival rates, outcomes and quality of life for those patients.

Summary of findings

- The trust had an outstanding programme of alternative and complimentary therapies on offer to help patients with their holistic health and wellbeing which surgical patients could access.
- The surgery directorate and wider trust displayed outstanding support and engagement for their staff. They used many different ways to engage with staff to keep them involved and included in decisions, changes and improvements within the trust. This in turn motivated and encouraged staff to improve their skills, qualifications and experience and become invested in the success of their organisation about which they were very proud.
- The surgery directorate uses the very latest state of the art surgical robots which allows surgeons to work with greater vision, precision, dexterity and control and which provides many positive outcomes and less complications for patients.

End of life services

- The Specialist Supportive Care Team (SCT), an overarching team that includes the pain service and palliative care team, used an innovative approach to their structure, which was recognised by NHS England and is now being rolled out across cancer centres throughout the country.
- GPs within Greater Manchester could access their patients' information electronically. Other GPs had to access the Christie Portal to view their patient's information.
- The service was initiating the 'goals of care' approach to help ensure that clinicians and patients truly understood each other's expectations regarding treatment and outcomes. At the time of our inspection, a small number of conversations had been trialled with patients. Clinicians told us that they found the approach ensured that conversations were easier to have and that they truly understood what their patients expected from them in their patient journey. Service leads were preparing to present this to the Cancer Vanguard for consideration for 'goals of care' being rolled out across the country.
- The team had worked to develop the 'Enhanced Supportive Care' initiative. This is a new initiative aimed at addressing more fully the needs of cancer patients. The doctor is the national lead for this initiative, which is now being rolled out by NHS England. The service received a national QiC (Quality in Care) patient care pathway award in February 2016 for this service.

Chemotherapy

- With the increase of outreach services highlighted in the five year strategy, quality was seen as paramount. To ensure standards did not fall, the Christie Quality Mark was introduced in 2014. With representatives from governance, nurses, governors, consultants and managers from the Christie and other trusts locally formed a working group to ensure consistency in standards was maintained.

Radiotherapy

- The opt-in physiotherapy lymphoedema service at Salford for patients who had breast cancer was extremely good practice to address the needs of patients who were unaware if they would develop lymphoedema following treatment.
- The world class research in radiotherapy and the development of the proton beam service.

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

Importantly, the trust should

Medical services

- Take appropriate actions to maintain temperatures within treatment rooms where medicines are stored.

Summary of findings

- Take appropriate actions to improve staff appraisal rates and mandatory training compliance.

Surgical services

- Ensure that trust policy concerning the disposal and 'wasting' of controlled drugs, where the full contents of a vial are not prescribed and administered are adhered to in theatres and recovery.
- Ensure full compliance with all aspects of the National Patient Safety Agency (NPSA) 'five steps to safer surgery' and the completion of the World Health Organisation (WHO) checklist, in particular the introduction of all staff members.
- Ensure full compliance with trust CVC insertion infection control precautions.
- Seek to improve the legibility of handwritten surgery consent forms.
- Ensure a consistent and compliant approach to the requirements of the Mental Capacity Act 2005 regarding the two stage assessment of a patient's capacity to consent to treatment.
- Improve the temporary environment used for the pre-operative clinic, until the new facilities become available.
- The service should consider increasing the numbers of staff with competency based qualifications in gaining consent.
- They should continue to work towards meeting all of the recommendations of the 'Implementation of the Faculty of Pain Medicine's Core Standards for Pain Management (2015)'.

Critical care

- Ensure information related to patients physical and psychological needs assessments in critical care are relayed to the staff on the ward on discharge.

End of life care

- The trust should consider implementing a way that individuals' faith needs can be met by the mortuary service.

Chemotherapy

- Improve mandatory training where there are pockets of low compliance
- Ensure rooms storing medicines are below 25°C.
- Review the attendance at divisional governance meetings to ensure staff attendance is adequate.
- Ensure that where required (sluice room on the ground floor of the Palatine Centre) is secured and that chlorine based cleaning products and hand sanitisers are stored securely at all times.

Radiotherapy

- Review the staffing level requirements for treatment radiographers.
- The trust should review the management structure and the skill mix in the radiography department and to consider roles for radiographers that include routine treatment delivery and review for patients and allows specialist registrars and consultants to treat more complex patients.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating

Outstanding



Why have we given this rating?

We gave the medical care services at The Christie Main Site an overall rating of 'Outstanding'. This was because: -

- Patients and relatives spoke very positively about the care and treatment they received. We made observations about the care people received and carried out a Short Observational Framework for Inspection (SOFI). Throughout our observation we saw excellent interactions between staff and patients. Staff interaction was kind, compassionate and very caring. Staff frequently engaged with the patients and their discussions with patients were friendly and sincere.
- Patient feedback from surveys such as the NHS Friends and Family Test, the cancer patient experience survey (CPES) 2013/14 and CQC's adult inpatient survey 2015 showed there was a high level of patient satisfaction and the feedback about the care and treatment provided was very positive.
- Patients were supported with their emotional and spiritual needs and were able to voice any concerns or anxieties. Patients and their relatives gave positive examples ranging from how their privacy and dignity was maintained to how staff across all levels consistently took the time to speak with them and supported and encouraged them in a positive way.
- There was a holistic and person-centred care approach to the delivery of care for patients across all age groups. We saw positive examples where patient's individual needs were met, such as patient activities that were planned and based on their personal preferences.
- Patients and their carers were offered a range of free of charge complimentary therapies and services such as 'Look good, Feel Better' and 'Colour Me Beautiful' to promote self-esteem. Patients spoke positively about the availability and accessibility of these services.

Summary of findings

- Patients and their relatives were offered a food voucher to use in the hospital's canteen if they did not like the food offered on the regular ward menus.
- There were systems in place to support vulnerable patients, such as patients living with dementia or a learning disability. The environment and facilities for teenage and young adult patients were age-appropriate and these patients were provided with a broad range of recreational activities.
- Services were planned and delivered to meet the needs of local people. Patients were admitted and discharged from the services in a timely manner. The services consistently achieved the 18 week referral to treatment standards and the 31-day and 62-cancer wait time standards during 2015/16.
- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and appropriately maintained premises. Suitable equipment was available to support patients. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs.
- The services monitored patient outcomes and cancer patient survival rates across a range of specialties and cancer types. Audit records showed patient outcomes had improved over time and survival rates for cancer patients were similar to or better than the England average for most cancer types.
- There was effective teamwork and clearly visible leadership within the services. Key risks to the services, audit findings and quality and performance was monitored through routine departmental and divisional governance and quality meetings.

Surgery

Outstanding



We rated surgery services as 'Outstanding' overall. This was because:

- There was a good culture of openness, reporting and investigation of incidents. There was evidence of positive improvements and changes made as a result of incidents.

Summary of findings

- There were robust systems in place for the safeguarding of vulnerable patients.
- Surgical and nurse staffing levels were good and compliance with mandatory training was satisfactory.
- Care and treatment was provided which followed relevant National Institute for Health and Care Excellence (NICE) guidance and best practice.
- Holistic attention was paid to the nutrition and hydration needs of patients.
- Pain was recognised, monitored and treated promptly and effectively. Patients said they were happy with the levels of pain control.
- Surgical outcomes were positive; data and statistics regarding mortality, complications, survival rates, quality of life and functionality recorded positive outcomes. High numbers of patients were involved in clinical and surgical trials.
- Staff were competent, experienced and well trained and there was a lot of support and encouragement for further personal and professional development.
- There were excellent examples of multidisciplinary working, which was coordinated and comprehensive.
- We found that patients were active partners in their care and were engaged in decisions and direction of their care.
- Patients' emotional and social needs were highly valued by staff and this was embedded into their plan of care.
- Patients' individual differences were recognised and accommodated without judgement or discrimination. Reasonable adjustments were made and care was tailored for individual needs.
- Feedback from people who used the service was continuously positive regarding the way they were treated by staff. They believed that staff went above and beyond their role in the way they care for their patients.
- There was a holistic and person-centred care approach to the delivery of care for patients across all age groups.

Summary of findings

- A wide range of complementary therapies, wellbeing and support services were provided to patients and their carers, most of which were free of charge.
- The surgical directorate at the Christie offered specialised bespoke surgical treatments to patients with unusual, complex and advanced cancers.
- There was good access and flow with good referral to treatment times, low rates of delayed transfers of care and discharges and low levels of cancelled operations.
- The directorate had a high level of satisfaction across all staff groups. There was a tangible, extremely positive culture amongst staff and they were proud of their organisation and the service they provided.
- The Christie commitment pledges provided consistently high levels of engagement with staff. The leaders inspired staff involvement and collaboration in innovation, improvement and raising standards.
- The organisation took steps to improve the health and wellbeing of their workforce by considering their holistic needs.
- The trust vision and strategy was cascaded and embedded across the surgery directorate. Staff had a clear understanding of what this involved and their role in that strategy.
- The leadership sought continuous improvement and innovation in the surgical procedures they delivered.
- The Christie was a national leader in cancer research including driving forward new surgical techniques and collaboration with other disciplines to.
- The directorate sought feedback from service users from various equality groups in order to assess performance ensure equality in hard to reach, minority and underrepresented groups. However:
- We found the operating theatres to be only partially compliant with the National Patient Safety Agency (NPSA) 'five steps to safer surgery' and the completion of the World Health Organisation (WHO) checklist.

Summary of findings

- We found that in theatres some staff did not always wear gloves when in direct contact with patients and masks were not always worn during insertion of a central venous catheter (CVC).
- We found the temporary environment of a portacabin being used for the delivery of a pre-operative assessment clinic was unsuitable as patient's records were not kept securely and patients were not afforded privacy at reception.
- We found that the directorate had an inconsistent approach to the application of the Mental Capacity Act 2005 and the assessment of a patient's capacity to consent to surgery and treatment.

Critical care

Good



We have judged that overall, the critical care services provided at The Christie NHS Foundation Trust were good because,

- There were systems in place for reporting and learning from incidents.
- There were sufficient numbers of suitably skilled nursing and medical staff to care for patients
- The unit had no never events, or serious incidents reported for critical care, between February 2015 and January 2016.
- The service took part in the intensive care national audit and research (ICNARC) data so we were able to bench mark its performance and effectiveness alongside other similar specialist trusts. The trust performed well overall.
- Incidents were reported and acted upon and used continuously as a service improvement tool. Safety thermometer data was collected and displayed in public areas for patients and relatives to view. The results were also shared with staff, together with the results from relative's surveys.
- The trust had an outreach team with 12 critical care trained, dedicated members of staff who supported wards in the early detection and treatment of acutely unwell patients.
- The team had a dedicated follow-up service who saw all medical patients on discharge from critical

Summary of findings

care, together with surgical patients who had been in critical care for more than four days or more, patients who required respiratory support and those experiencing delirium.

- We reviewed the critical care patient experience survey for the period of March 2015 to March 2016. 87% of relatives rated the staff as 'Excellent' when asked at how caring they were towards their relative and 12.5 % rated the care as 'Good' when asked the same question.
- Staff and relatives gave us many examples of staff interacting with patients in a caring manner that went above and beyond their general role.
- The unit had overnight accommodation attached to the unit, available for relatives to stay. It was clean and well equipped with en-suite shower facilities.
- The complementary therapy team attended the unit daily, Monday to Friday, and offered therapies to patients and relatives, such as; head and neck massage, aromatherapy and visualisation.
- relatives.
- There was a comprehensive selection of clinical governance meetings both within the trust and at Network level.
- There was an effective governance structure in place, which ensured that all risks to the unit were discussed within the trust and through regional networks.

End of life care

Outstanding



Overall we rated EOL care at the Christie as outstanding because:

- Incident reporting systems were in place and learning from incidents was discussed. There had been no recent serious incidents related to end of life care.
- There was an audit plan in place and actions from audits were contained within action plans and being addressed.
- The service held a weekly multi-disciplinary team (MDT) meeting where cases and new referrals were discussed. Representation from a wide number of different disciplines attended and we saw evidence of good collaborative working across the different agencies and teams.

Summary of findings

- We saw evidence that people's individual needs were being considered at end of life and that discussions with patients and their families were taking place. Referrals to the SCT team were priority rated and ward staff told us the SCT responded quickly to requests for their input.
- The service was deemed compliant with NICE guidance by NICE.
- The SPC team used an innovative approach to their structure, which was recognised by NHS England and is now being rolled out across cancer centres throughout the country.
- The service achieved six out of eight performance indicators in the NCDAH 2016. An action plan was in place to address the other two indicators.
- Staff provided sensitive, caring and individualised personal care to patients who were at the end of their life.
- Awareness of the specialist team was embedded in all clinical areas of the hospital. They were professional, responsive and supportive of patients, relatives and staff.
- The service was carrying out trials and initiatives to improve EOL care for patients within the trust but also across other organisations.

Outpatients and diagnostic imaging

Good



There was a culture of reporting and learning from incidents with the majority reported as low or no harm. A radiation protection service supported and supervised staff.

Areas were visibly clean and tidy. Regular audits showed 100% compliance with good practice. Rooms and waiting areas were fit for purpose, although some areas were small. Infrastructure was reviewed and refurbished when required. Equipment was in good working order and checked regularly. Medicines and diagnostic imaging chemicals (such as contrast) were stored correctly. Records were stored appropriately and included the right details about patients.

Staff did mandatory training including safeguarding. Processes were in place to support staff highlighting safeguarding concerns. Staff received training for major incidents where appropriate.

Services managed patient risks with processes to identify and treat unwell patients.

Summary of findings

Staffing levels were adequate. Regular meetings enabled managers to share information. Staff developed in their roles, maintained competencies and received annual appraisals. Care and treatment was evidence based, with regular research undertaken. Diagnostic imaging staff complied with Ionising Radiation (Medical Exposures) Regulations 2000. Regular meetings ensured radiology reporting standards were maintained.

Multi-disciplinary care was provided internally and regionally. Services were provided Monday to Friday, with extra hours added if capacity issues arose. Radiology reporting was available out of hours. Staff could access and share required information. They worked on the basis of implied or verbal consent day to day, and written consent for more invasive procedures.

Feedback from people was continually positive. They described staff listening, considering needs and addressing concerns when answering questions. We saw staff recognising needs and providing kind, considerate care.

The Christie Information Service provided a wide range of information. A hotline telephone service was available 24 hours a day, seven days a week providing advice and support. Information leaflets were also available.

Staff were familiar with local and individual patient needs. Transport, translation, chaplaincy, complementary therapy and free Wi-Fi helped ensure needs were met.

Targets were being met consistently. Wait time, delays and cancellations were minimal.

There was a process in place for people to raise concerns. Minimal numbers of complaints were received.

Services had a vision and strategies in place to improve services. Risk registers were used to monitor risks and regular governance meetings took place. Staff said managers had an 'open door' approach visiting staff and offering support.

The culture emphasised person centred care, and preventative multi-disciplinary treatment and support. Staff felt privileged to care for patients. Engagement with the public and staff took place.

Summary of findings

The Christie facilitated a wide range of clinical trials to find new and effective cancer treatments. Exploration of ideas took place and formed plans for the future.

Chemotherapy

Outstanding



There was a culture of reporting and learning from incidents. Staff were aware of the Duty of Candour, adopting principles in everyday practice. Areas were visibly clean and tidy. Staff undertook cleaning duties and cleanliness and hygiene was reflected in audit results. Environments were light and spacious with age appropriate decoration. Equipment was serviced regularly. Medicine was stored securely and managed appropriately. Staff provided care using national guidance which was reviewed regularly to ensure compliance. Local protocols were devised in line with current treatment and clinical trials. Pain was managed using core standards and patients described being offered a range of pain relief to manage their pain effectively. Food and refreshment was available for patients and visitors. Chemotherapy services took part in research and contributed to the trust's reputation as an international leader for research, offering clinical trials to patients. People received multi-disciplinary care which was discussed regularly in team meetings. Staff worked collaboratively to understand and meet complex needs as well as offering advice to other healthcare professionals. Staff access information regardless of whether they were on the main site or working remotely. There were processes in place for staff to follow in relation to the Mental Capacity Act 2005, best interest decision making and Deprivation of Liberty Safeguards. Consent processes was sourced and recorded appropriately. Feedback was continually positive about staff 'going the extra mile' and listening willingly before giving reassurance. Some patients had years of experience demonstrating staff attitudes were well established and saw staff treat patients with kindness and good humour.

Summary of findings

Information and support services were available for patients and loved ones, including a range of complimentary therapies. A specialist 'calm' service helped patients experiencing anxiety. Children, teenagers and young people were catered for in a purpose built environment with activities and events planned each day to enhance time spent in the department. Play specialists helped ease treatment. Services were consistently meeting targets to provide timely care. Whilst some patients described waiting time as an issue, staff tried new initiatives which improved the situation. Reasonable adjustments were made for people to access services with sign language, hearing loops and language translation available. Complaints and concerns were managed appropriately and within a suitable time scale. Staff described the vision to expand treatment for patients closer to home. Other healthcare providers came to see how outreach services were managed successfully. Staff felt supported by managers who operated an 'open door' policy. They felt empowered to improve services; raising money to make improvements. Executive leaders had a visible presence. Patients were invited to forums to help shape new services.

Radiotherapy

Outstanding



The radiotherapy service at the Christie hospital provided safe and effective care for its patients. Up to date techniques and technologies were used to ensure that patients received treatment to improve their outcomes and to reduce the short and long term effects of radiotherapy treatment. There was a focus on research and clinical trials. There was strong evidence of multi-disciplinary working and continuing education for staff. Care was very patient focused and holistic with a strong focus on maintaining physical and mental well-being during treatment. Targets were met and there was good governance, risk management and quality assurance in the department. However there were some issues with staffing of radiographers in one part of the department.

The Christie Main Site

Detailed findings

Services we looked at

Medical care ; Surgery; Critical care; End of life care; Outpatients and diagnostic imaging; Chemotherapy; Radiotherapy

Detailed findings

Contents

Detailed findings from this inspection

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Background to The Christie Main Site

The Christie NHS Foundation Trust is a 188 bed (including critical care) comprehensive cancer centre serving a population of 3.2million people across Greater Manchester and Cheshire, with 26% of patients being referred to us from across the UK.

NHS activity is commissioned by the specialist commissioners of NHS England with over 90% of activity being ambulatory care. We have an annual turnover of £230 million, operating with 2,500 staff, 350 volunteers, 27,500 public members and have one of the largest hospital charities.

The Networked Services division provides clinical and medical oncology services across Greater Manchester & Cheshire, clinical haematology and transplantation, teenage and young adult services and specialist endocrinology. The clinical and medical oncology services include the delivery of radiotherapy on the Withington site and at two satellite centres at local provider sites. The Cancer Centre Services Division includes surgery (including anaesthetics and theatres), the surgical day case unit, critical care, oncology assessment unit and outpatients and diagnostics.

Our inspection team

Our inspection team was led by:

Chair: Mr Leslie Hamilton

Inspection Manager : Bridget Lees, Care Quality Commission

The team included an inspection manager, 7 CQC inspectors, 2 radiology CQC specialists, a CQC pharmacist, inspection planner, an assistant planner, a senior analyst and a variety of specialists including :

a clinical oncologist, a palliative nurse specialist, consultant urologist surgeon, an operating theatre practitioner, a consultant anaesthetist, a nurse consultant critical care, a paediatric oncology nurse, a consultant in clinical oncology, a cancer nurse specialist, a consultant in clinical oncology/radiotherapy, a radiographer, a director of nursing, a safeguarding specialist, an equality and diversity specialist and a pharmacist.

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Detailed findings

Is it well-led?

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

We held a listening event for people who had experienced care at The Christie NHS Foundation Trust on the 4th May 2016 in The Christie hospital. The event was designed to take into account people's views about care and treatment received at the hospital. Some people also shared their experiences by email and telephone. The announced inspection of The Christie NHS Foundation Trust 10th – 13th May 2016.

The inspection team inspected the following core services at The Christie NHS Foundation Trust

- Medical care
- Surgery
- Critical care
- Outpatients and Diagnostic Imaging

- End of life care

- Chemotherapy
- Radiotherapy

As part of the inspection, we held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters.

We also spoke with staff individually as requested. We talked with patients and staff from all the ward areas and outpatients services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We undertook an unannounced inspection between 12pm and 5pm on 25th May 2016 at The Christie hospital and The Christie Mobile Chemotherapy Unit. As part of the unannounced inspection, we looked at medicine, chemotherapy and radiotherapy. We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at The Christie NHS Foundation Trust.

Facts and data about The Christie Main Site

The trust serves a population of 3.2million people across Greater Manchester and Cheshire. In addition, 26% of the patients referred to the trust are from across the UK.

Across the three local authorities spanned by the trust, the majority of indicators in the local health profile are below the England average, particularly on the mortality indicators.

Manchester local authority has an average deprivation score of 40, putting them in the most deprived quintile when compared to other local authorities in England.

Around 40% of LSOAs in this Local Authority are in the most deprived 10%.

There are 188 oncology beds including eight critical care beds.

In 2014/15 there were 10,827 inpatient admissions and 335,002 outpatient (total attendances).

At the time of inspection there were 2436 whole time equivalent (wte) staff, of which 242 wte were medical staff, 554 wte nursing and 1640 wte other staff disciplines.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Surgery	Requires improvement	Good	Outstanding	Outstanding	Outstanding	Outstanding
Critical care	Good	Good	Good	Good	Good	Good
End of life care	Good	Outstanding	Outstanding	Good	Outstanding	Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Outstanding	Good	Good	Good
Chemotherapy	Good	Good	Outstanding	Good	Outstanding	Outstanding
Radiotherapy	Good	Outstanding	Outstanding	Outstanding	Good	Outstanding
Overall	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding

Notes

Medical care

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

Information about the service

The Christie NHS Foundation Trust is one of the largest single site cancer centres in Europe. It serves a population of 3.2 million people across Greater Manchester and Cheshire while 26% of patients are referred from across the UK.

The medical care services are provided at the Christie Main Site at Withington in Manchester. Services include clinical oncology, medical oncology, endocrinology, clinical haematology and brachytherapy. There were 14,144 admissions at the hospital between September 2014 and August 2015. Medical oncology patients accounted for 43% of admissions, followed by clinical oncology (32%) and clinical haematology (18%).

We visited the Christie Main Site as part of our announced inspection during 10 to 13 May 2016. We also carried out an unannounced inspection on 25 May 2016.

As part of the inspection, we visited the oncology assessment unit (21 bedded urgent and unplanned admissions ward), Palatine ward (31 bedded integrated adult haematology and young oncology ward), Ward 4 (34 bedded clinical oncology ward, comprised of 24 general oncology beds and 10 radioiodine and brachytherapy molecular radiotherapy beds (BMRU)), Ward 11 (28 bedded medical and clinical oncology ward, plus haematology outliers) and Ward 12 (28 bedded medical and clinical oncology ward, plus haematology outliers). We also visited the clinical trials unit, the young oncology day case unit, the endocrinology unit and the planned admissions and transfers (PAT) suite.

We spoke with 10 patients and the relatives of another five patients. We observed care and treatment and looked at 12 care records. We also spoke with a range of staff at different grades including pharmacy technicians, a pharmacist, physiotherapists, nurses, domestic staff, volunteers, a ward hostess, healthcare assistants, senior charge nurses (ward managers), consultants, junior doctors, clinical fellows, the safeguarding lead, the clinical performance lead, matrons, clinical directors and the chief operating officer. We received comments from our engagement event and from people who contacted us to tell us about their experiences. We reviewed performance information about the trust.

Medical care

Summary of findings

We gave the medical care services at The Christie Main Site an overall rating of 'Outstanding'. This was because:

- Patients and relatives spoke very positively about the care and treatment they received. We made observations about the care people received and carried out a Short Observational Framework for Inspection (SOFI). Throughout our observation we saw excellent interactions between staff and patients. Staff interaction was kind, compassionate and very caring. Staff frequently engaged with the patients and their discussions with patients were friendly and sincere.
- Patient feedback from surveys such as the NHS Friends and Family Test, the CQC's adult inpatient survey 2015 showed there was a high level of patient satisfaction and the feedback about the care and treatment provided was very positive.
- Patients were supported with their emotional and spiritual needs and were able to voice any concerns or anxieties. Patients and their relatives gave positive examples ranging from how their privacy and dignity was maintained to how staff across all levels consistently took the time to speak with them and supported and encouraged them in a positive way.
- There was a holistic and person-centred care approach to the delivery of care for patients across all age groups. We saw positive examples where patient's individual needs were met, such as patient activities that were planned and based on their personal preferences.
- Patients and their carers were offered a range of free of charge complimentary therapies. Patients spoke positively about the availability and accessibility of these services.
- Patients and their relatives were offered a food voucher to use in the hospital's canteen if they did not like the food offered on the regular ward menus.
- There were systems in place to support vulnerable patients, such as patients living with dementia or a

learning disability. The environment and facilities for teenage and young adult patients were age-appropriate and these patients were provided with a broad range of recreational activities.

- Services were planned and delivered to meet the needs of local people. Patients were admitted and discharged from the services in a timely manner. The services consistently achieved the 18 week referral to treatment standards and the 31-day and 62-cancer wait time standards during 2015/16.
- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and appropriately maintained premises. Suitable equipment was available to support patients. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs.
- The services monitored patient outcomes and cancer patient survival rates across a range of specialties and cancer types. Audit records showed patient outcomes had improved over time and survival rates for cancer patients were similar to or better than the England average for most cancer types.
- There was effective teamwork and clearly visible leadership within the services. Key risks to the services, audit findings and quality and performance was monitored through routine departmental and divisional governance and quality meetings.

However, we also found that: -

- Medicines were ordered, stored and discarded safely and appropriately. However, the temperatures of the treatment rooms where medicines were stored the temperatures routinely fluctuated above 25°C. A risk assessment had been carried out and additional controls included limiting the number of medicines stored in treatment rooms to reduce their exposure to higher temperatures.

Medical care

- The majority of staff had completed their annual appraisals (83.7%) and mandatory training (82%). However, the hospital's internal target of 95% mandatory training and appraisal completion had not been achieved across all the medical specialties.

Are medical care services safe?

Good



We rated the medical care services at The Christie Main Site as 'Good' for being safe. This was because: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and appropriately maintained premises. Suitable equipment was available to support patients. Patient records were completed appropriately.
- The staffing levels and skills mix was sufficient to meet patients' needs. There were systems in place to manage resource and capacity risks and to manage patients whose condition was deteriorating through the use of an early warning score system. Staff were aware of how to access guidance in the event of a major incident.
- Medicines were ordered, stored and discarded safely and appropriately. However, the temperatures of the treatment rooms where medicines were stored the temperatures routinely fluctuated above 25°C. A risk assessment had been carried out and additional controls included limiting the number of medicines stored in treatment rooms to reduce their exposure to higher temperatures.

However, we also found that: -

- Most staff (82%) had completed their mandatory training but this was below the hospital's internal target of 95% training completion.

Incidents

- There had been no 'never events' reported in relation to medical care services at the hospital between February 2015 and May 2016. A 'never event' is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.
- The Strategic Executive Information System data showed there was one serious patient safety incident reported by the medical services between February 2015 and January 2016. The incident occurred in June 2015 and was categorised as 'apparent / actual / suspected self-inflicted harm'.

Medical care

- We saw evidence that incident was investigated to determine the root cause and remedial actions were implemented to improve patient care. The remedial actions implemented in September 2015 included developing a trigger list for staff to refer patients for psychiatric triage and for staff to carry out mood assessments at set intervals for patients identified as at risk.
- The National Reporting and Learning System (NRLS) data showed there were 750 incidents reported relating to the medical services between February 2015 and January 2016. The majority of these incidents (98.7%) resulted in no or low harm.
- The NRLS data showed the most frequent incidents reported related to 'medication' (36.4%), 'treatment / procedure' (28.7%) and 'patient accident' (25.8%). We saw evidence that these incidents were investigated and remedial actions were implemented to improve patient care.
- Records showed 68.1% of medical care incidents were reported to the NRLS within 30 days and 92.7% were reported within 60 days. This showed there was a positive culture of incident reporting.
- Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated by ward and theatre managers to look for improvements to the service. Serious incidents were investigated by a multidisciplinary team of trained staff with the appropriate level of seniority, such as the senior nurses and matrons.
- The matrons and senior nurses carried out weekly and monthly reviews of incidents to look for trends and to improve practice and the service to patients. Staff told us they received verbal feedback about incidents reported. Incidents were discussed during daily 'safety huddles' and weekly and monthly staff meetings so shared learning could take place. Learning from incidents was also shared through hospital-wide alerts and monthly newsletters.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- Patient deaths were reviewed by individual consultants within their specialty area. These were also presented and reviewed at monthly and three-monthly mortality and morbidity meetings.

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, blood clots, catheter and urinary infections).
- Safety Thermometer information between February 2015 and February 2016 showed there were no pressure ulcers, falls with harm or catheter urinary tract infections reported by the hospital relating to the medical services.
- Information relating to the NHS Safety Thermometer was clearly displayed on electronic screens at the entrance in each of the wards we inspected.

Cleanliness, infection control and hygiene

- There had been no MRSA bacteraemia infections and 17 Clostridium difficile (C.diff) infections relating to medical services at the hospital between April 2015 and March 2016. All the C.diff incidents were classed as 'unavoidable' which meant they were not caused as a direct result of lapses in the care provided by the services.
- We looked at the investigation reports for two C.diff incidents from January 2016. These showed that the incidents had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trust's infection control team.
- The wards and clinical areas we inspected were clean and tidy. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance. Visitors were encouraged to wash their hands.

Medical care

- Water sampling was undertaken in May 2014 to ensure water safety prior to the opening of the Palatine ward. This identified *Pseudomonas* bacteria was present in a number of water outlets across the ward.
- This was identified as a 'moderate' risk on the departmental risk register. A number of actions were taken to minimise the risks of spread of infection. This included installing water filters to all water outlets (e.g. sinks), routine sampling of water outlets to monitor the levels of *Pseudomonas* and guidelines for staff and visitors to maintain hand hygiene standards upon entry to the ward and in between patient contact.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care.
- Patients identified with an infection were isolated in side rooms. We saw that appropriate signage was used to protect staff and visitors.
- Hand hygiene audits were carried out on a monthly basis across the medical wards. Audit results from January 2016 to April 2016 showed 100% compliance was consistently achieved by staff across the medical services.
- Staff carried out routine infection control audits to check the cleanliness of the general environment and equipment. We looked at two infection control audit reports from the medical wards and these showed the wards had achieved the hospital's internal standard of greater than 85% compliance. Where any issues were identified, these were followed up at the next audit to minimise the risk of spread of infection.

Environment and equipment

- The wards and clinical areas we inspected were well maintained, free from clutter and provided a suitable environment for treating patients.
- Equipment was appropriately checked and cleaned regularly and the equipment we saw had service stickers displayed and these were within date. Single-use, sterile instruments were stored appropriately and were within their expiry dates.
- Equipment was serviced by the hospital's maintenance team under a planned preventive maintenance schedule. Staff told us that all items of equipment were readily available and any faulty equipment was either repaired or replaced promptly.

- There was sufficient storage space across the ward areas and equipment was appropriately stored in a tidy and organised manner.
- Emergency resuscitation equipment was available and checked on a daily basis by staff.

Medicines

- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- Medicines were ordered, stored and discarded safely and appropriately. A pharmacy technician carried out at least three visits per week on each ward to check stock levels and medication expiry dates.
- We saw that medicines that required storage at temperatures below 8°C were appropriately stored in medicine fridges. Fridge temperatures were monitored daily to check medicines were stored at the correct temperatures.
- Temperature logs showed specified fridge temperatures were maintained on the majority of occasions. However, we found instances where daily fridge temperatures had exceeded the maximum temperature of 8°C. For example, the maximum fridge temperature was logged as 9.5°C between 19 and 21 May 2016 on ward 12. The fridge temperatures recorded on the Palatine ward also ranged between 8.1°C and 11.6°C on a number of occasions during May 2016.
- We saw evidence that staff notified the maintenance team and the pharmacy department on each occasion where fridge temperatures exceeded the maximum temperature range.
- Medicine fridges and some intravenous (IV) fluids were kept in treatment rooms where the temperatures routinely fluctuated above 25°C. Temperature logs showed the treatment room temperatures ranged between 25°C and 29°C on at least five occasions during May 2016 on ward 11, ward 12 and the Palatine ward.
- We saw this issue was logged as a risk on the hospital's operational risk register. The director of pharmacy services had carried out a hospital-wide risk assessment in relation to room temperatures exceeding 25°C. Additional controls had been put in place to ensure medicines were appropriately stored. This included limiting the number of medicines stored in treatment rooms and drug fridges to minimise the length of time

Medical care

medicines could be exposed to higher temperatures. The long-term plans to address the issue included the installation of adequate air-conditioning systems as part of future ward refurbishment programmes.

- A pharmacist carried out daily reviews on each ward. The pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.
- We looked at the medication charts for 12 patients and found these to be complete, up to date and reviewed on a regular basis. We also looked at the medication charts of eight patients receiving oxygen treatment. These showed that the use of oxygen had been appropriately prescribed and documented correctly.

Records

- We looked at the records for 12 patients. These were structured, legible, complete and up to date. Patient's care plans were person-centred and completed to a good standard.
- Staff used an electronic patient record for documenting items such as risk assessments and care plans.
- The electronic patient record system was developed in-house and could be customised to meet the needs of specific medical specialty areas. This meant care pathways and care plans could be modified following changes to standard operating procedures or national guidelines.
- Patient records included risk assessments, such as for falls, venous thromboembolism, pressure care and nutrition and these were reviewed and updated on a regular basis. The electronic system prompted staff when risk assessments required updating.
- Paper patient records were used for standardised nursing activities, such as daily observations and prescription charts and these were kept at each patient's bed side. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received statutory training in the safeguarding of vulnerable adults and children. Records from May 2016 showed the majority of staff across the medical services (95%) had completed training in safeguarding children

and adults. However, 68% of staff across the medical services had completed safeguarding children level 2a training and this was below the hospital's internal target of 95% completion.

- Staff were aware of how to identify abuse and report safeguarding concerns. Information on how to report adult and children's safeguarding concerns was displayed in the areas we inspected. Each area also had safeguarding link nurses in place. Staff were aware they could seek advice and support from the hospital-wide safeguarding team.
- Safeguarding incidents were reviewed by the matrons and also by the hospital's 'safeguarding vulnerable people committee', which held meetings at least every two months to review individual incidents and to look for trends.
- Ward staff told us they received individual feedback from safeguarding referrals that they had made. The incident reporting system included an option for the staff making a referral to request individual feedback. The system did not allow the safeguarding incident to be closed until evidence of feedback had been recorded.
- Staff also received collective feedback about safeguarding incidents through routine meetings and in daily safety huddles.

Mandatory training

- Staff received mandatory training, which included key topics such as infection control, safeguarding children and vulnerable adults, equality and diversity, medicines management, mental capacity act, dementia care and moving and handling training.
- Mandatory training was delivered on a rolling programme and monitored on a monthly basis.
- Records up to May 2016 showed the overall mandatory training completion rate for staff across the medical services was 82%. This showed the majority of staff had completed their mandatory training but the hospital's target of 95% training completion had not been achieved.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues and there was daily involvement by ward managers and matrons to address these risks.

Medical care

- On admission to the medical wards, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism, pressure ulcers, nutrition, and risk of falls and infection control risks.
- Patients at high risk were placed on care pathways and care plans were put in place so they received the right level of care.
- Staff carried out hourly 'intentional rounding' observations so any changes to the patient's medical condition could be promptly identified.
- Staff used modified early warning score systems (MEWS) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified. If a patient's health deteriorated, staff were supported with medical input and were able to contact the critical care outreach team if needed.
- A MEWS audit was carried out during April 2015 and the findings were based on a review 60 records across the medical wards. The audit showed the compliance standard of at least 85% had been achieved across the seven standards of the audit.
- This included all sets of observations undertaken in last 24 hours were fully complete (85%), MEWS score calculated correctly (95%) and observations carried out as indicated by the set monitoring frequency (95%).
- Records showed the average shift fill rates for nursing and care staff on the medical wards were consistently above 95% between January 2016 and April 2016.
- There were approximately six whole time equivalent (wte) nursing vacancies and approximately three wte healthcare assistant vacancies across the medical wards.
- Recruitment for the vacant posts was on-going. For example, the ward manager on ward 11 told us two nurses had recently commenced employment and four additional nurses were due to commence employment in September 2016.
- The ward managers told us the recruitment plan included over-establishment (i.e. more staff than planned) in order to reduce the impact of short-term sickness or staff leaving the services.
- The ward managers and matrons told us they rarely used external agency staff. Records showed external agency staff usage across the hospital was 0.62% between April 2015 and March 2016 and this was within the hospital's target of below 1%.
- Staffing levels were maintained through the use of bank staff made up from the existing ward staff across the hospital. Records showed the bank staff usage across all the medical wards was consistently below 5% during 2015.
- Nursing staff handovers took place during daily shift changes and these included discussions about patient needs and any staffing or capacity issues. Patients spoke positively about the staff and did not highlight any concerns relating to staffing levels.
- The nursing staff were supported by a number of advanced nurse practitioners (ANP's) that worked across the medical services. For example, there were five ANP's covering the oncology assessment unit (OAU) and two ANP's covering the planned admissions and transfers (PAT) suite. The ANP's duties including the review of patients and medication prescribing.

Nursing staffing

- Nurse staffing levels were reviewed every six months against minimum compliance standards, based on national NHS safe staffing guidelines. The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- The matrons and ward managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. The ward managers told us staffing levels were based on the dependency of patients and this was reviewed daily. We saw that staffing levels on the wards were increased so patients needing 1:1 care could be appropriately supported.
- The wards we inspected had sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.

Medical staffing

- The wards and clinical areas we inspected had sufficient numbers of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The proportion of consultants and registrars across the medical services at the hospital was greater than the England average. The proportion of middle career

Medical care

doctors was below the England average (4% compared with the England average of 6%). The proportion of junior doctors was also below the England average (1% compared with the England average of 22%).

- There were separate medical rotas in place to cover specific specialties, such as head and neck and gastroenterology, chest and gynaecology, and urology, lymphoma and melanoma.
- There was sufficient on-site and on-call consultant cover over a 24-hour period including cover outside of normal working hours and at weekends. The on-call consultants were free from other clinical duties to ensure they were available when needed.
- The medical oncology specialty had 33 consultants (including academics), with one vacancy and an additional vacancy due to maternity leave. The maternity leave post was covered by the existing team. Interviews for the vacant post were due to commence in June 2016.
- The clinical oncology specialty had 42 consultants (including academics), with no vacancies. There were six consultants across the haematology specialty (including an honorary consultant that supported the on-call rota) with no vacancies.
- There was at least one on-call registrar per specialty over a 24 hour period. There were 10 specialist registrars covering clinical oncology with one vacant post due to maternity leave. There were five registrars and two clinical fellows covering the haematology service, with no vacancies.
- The clinical oncology service had 10 registrars in post against a planned establishment of 15. Three clinical fellows had been appointed to address the shortfall and these were awaiting start dates.
- The Palatine ward had two middle grade paediatric doctors, with at least one available on site over a 24-hour period.
- Staff rotas showed there was sufficient on-site junior doctor, middle grade and registrar cover across each specialty over a 24-hour period. There were at least three junior or middle grade doctors covering each specialty area.
- There were nine foundation year 2 (FY2) junior doctors in post, including seven covering the oncology services.
- There were 11 core medical trainee (CMT) doctors in post, including five covering oncology, three covering

haematology and two covering the endocrinology specialties. The CMT rota was a 12-person rota so an additional junior oncology fellow (JOF) was also included in the rota to allow sufficient shift coverage.

- There were five junior oncology fellows (JOF) in post (including the JOF covering the CMT rota). Three of the JOF's were due to complete their residency during May 2016, which meant there was a shortfall of three JOF posts. One of these posts had been recruited to (commencing employment from June 2016) and the remaining posts were planned to be covered through the use of agency staff.
- Staff rotas were mostly maintained by the existing staff during periods of leave or sickness. Records showed there was low usage of agency or locum doctors. During 2014/15 only 34 shifts across the clinical oncology, haematology and medical oncology specialties had been covered using locum or agency doctors.
- Where locum or agency doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures.
- The ward and theatre staff told us they received good support from the consultants and ward-based doctors.
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Major incident awareness and training

- There was a documented major incident and business continuity plan within medical areas and this listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff across the medical services had completed resuscitation training and staff had guidelines in place for dealing with medical emergencies such as a patient going into cardiac arrest.

Are medical care services effective?

Good



We rated the medical care services at The Christie Main Site as 'Good' for being effective. This was because: -

Medical care

- The services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits.
- The services monitored patient outcomes and cancer patient survival rates across a range of specialties and cancer types. Audit records showed patient outcomes had improved over time and survival rates for cancer patients were similar to or better than the England average for most cancer types.
- The services were not eligible to participate in the National Diabetes Inpatient Audit (NaDIA). However, a snapshot audit of diabetes in patient care was carried out and the findings were benchmarked against NaDIA results in order to improve the care received by patients with diabetes.
- Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.
- Staff used care pathways that were based on national best practice guidelines, such as for sepsis care, acute kidney injury and for the treatment of suspected and confirmed lung cancer.
- The medical services also collaborated with the Greater Manchester and Cheshire Cancer Network to develop care pathways and best practice guidelines.
- During 2015/16 the hospital participated in 100% of the national clinical audits and national confidential enquiries which it was eligible to participate in. The networked services division (medical services) completed 76 local clinical audits during this 2015/16. The draft annual clinical audit programme 2016-17 outlined the planned participation in local and national audits over the next year.
- Findings from clinical audits were reviewed during monthly quality and audit meetings and any changes to guidance and the impact that it would have on their practice was discussed.
- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We looked at a selection of the hospital's policies and procedures and these were up to date and reflected national guidelines.

However, we also found that: -

- The services performed worse than the England average for average length of patient stay at the hospital and for the proportion of patients readmitted to the hospital following their discharge. However, this was likely due to the specialist nature of the care and treatment provided by the hospital and the complex health needs of some cancer patients.
- The majority of staff (83.7%) had completed their annual appraisals. However, the hospital's internal target of 95% appraisal completion had not been achieved across all the medical specialties.

Evidence-based care and treatment

- Staff followed policies and procedures based on national guidelines, such as the National Institute for Health and Care Excellence (NICE) as well as guidance published by the relevant medical bodies such as the Royal Colleges.

Pain relief

- Staff used pain assessment charts to monitor pain symptoms at regular intervals. Patients told us staff gave them pain relief medication in a timely manner.
- The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort.
- There was an acute pain team within the hospital and staff knew how to contact them for advice and treatment when required.

Nutrition and hydration

- Patient records included assessments of patients' nutritional requirements. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients did not eat enough, this was addressed by the medical staff to ensure patient safety and comfort. Patient records also showed that there was regular dietician involvement with patients who were identified as being at risk.

Medical care

- Patients with difficulties eating and drinking were placed on special diets or provided with 'finger foods' to facilitate their eating. We also saw that the medical wards used a 'red tray' system so patients that required assistance (such as patients living with dementia) could be identified and supported by staff during mealtimes.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.

Patient outcomes

- The overall five-year survival rate for patients diagnosed with cancer of the cervix, breast, lung, prostate, skin and rectum showed significant improvements for the majority of patients between 2005 and 2015.
- The clinical outcomes for Christie colorectal, upper gastro-intestinal (UGI) and breast cancer patients report from May 2016 showed overall one-year survival for patients with breast cancer was 95%, UGI cancer was 52% and colorectal cancer was 89%.
- The overall one-year survival rate for patients with brain and central nervous system (CNS) tumours varied by tumour type with patients with glioblastoma (GBM) showing the worst outcomes. GBM is the most common and aggressive primary malignant brain tumour in adults. A report from July 2015 showed the one-year survival rate for patients with GBM was 27.4%, which was comparable to the England average of 28.4%.
- The head and neck cancer report from February 2015 showed one year survival from diagnosis for cancer of the larynx among patients who received their first treatment at the hospital was 88%, which was better than the estimated England average of 85%.
- One year survival for prostate cancer for all patients receiving primary treatment at the hospital was approximately 98%, compared to the estimated England average of 93.6%.
- Audit reports from 2015 and 2016 showed the overall one-year survival rates for patients with skin melanomas; Hodgkin lymphoma and cancer of the bladder were also comparable to estimated England averages based on Cancer Research UK data.
- The Christie stem cell transplant programme annual report for 2015 had not yet been published. Data from the 2014 annual report showed one-year survival rates for autologous (patient's own stem cells) and allogeneic (other person's marrow or stem cells) transplants remained largely unchanged over the last decade. The one year survival rates were also equivalent or better than national figures from the British Society of Blood and Marrow Transplantation (BSBMT) 2013 report.
- The stem cell transplant report also showed that over the last decade (2004 – 2013), 100 day non-relapse mortality for both autologous and allogeneic transplants had decreased. The improvement was likely due to improved supportive care and increased numbers of reduced-intensity / mild dose (myeloablative) procedures undertaken.
- The systemic anti-cancer therapy (SACT) data completeness report showed the trust performed better than the England average for 24 out of the 47 measures and worse than England average for eight measures. Performance against SACT standards was monitored through monthly SACT delivery group meetings.
- The overall treatment related mortality for patients receiving SACT was less than 1%. Records showed the overall mortality rate had improved from 0.47% in 2009/10 to 0.36% during 2014/15.
- The diabetes specialist nurse told us the hospital had been advised that it could not participate in the National Diabetes Inpatient Audit (NaDIA) as the results would 'skew' the national results. However, the diabetes specialist nurse carried out a snapshot audit of diabetes in patient care and the findings were benchmarked against NaDIA results.
- The diabetes audit summary from November 2015 showed the snapshot audit findings were comparable to the national NaDIA results. However, further improvements were needed in areas such as diabetes foot review and glucose monitoring. Remedial actions to improve compliance included reviewing data by each ward and providing additional training for staff. A further audit was scheduled to benchmark results against NaDIA results after June 2016.
- The proportion of non-elective patients that were readmitted to hospital following discharge was similar to the England average. However, the readmission rate for elective patients was higher than the England average.
- The average length of stay for elective and non-elective patients across all medical specialties was also longer than the England average.

Medical care

- The specialist nature of treatments provided by the hospital and the complex health needs of some cancer patients meant the staff actively encouraged patients to contact the hospital for readmission if they experienced any adverse medical symptoms.
- The hospital reported that reducing length of stay and readmission rate was not advocated for cancer patients and that the hospital was exempt from the national reporting of patient readmission within 28 days.

Competent staff

- Newly appointed staff had an induction for up to four weeks and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- There was a preceptorship programme in place to support newly qualified nursing staff and their competency in the delivery of care and treatment was assessed.
- Staff told us they routinely received supervision and annual appraisals. Records up to February 2016 showed the overall appraisal rate across the clinical networked services division was 83.7%. This showed that although the majority of staff had completed their appraisals, the hospital's internal target of 95% had not been achieved across all the medical specialties.
- Records showed all eligible medical staff in the medical services that had reached their General Medical Council revalidation date had been reviewed and recommendations had been completed.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the medical wards. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- Consultant ward rounds occurred a number of times per week and included multidisciplinary input from nursing, pharmacy and physiotherapy where required.

- We saw that weekly multidisciplinary meetings took place with staff from other hospitals to discuss the needs of patients receiving care from more than one healthcare provider.
- There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals.
- The ward staff told us they had a good relationship with consultants and ward-based doctors. They also told us they received good support from pharmacists, dietitians, physiotherapists, occupational therapists as well as diagnostic support such as for x-rays and scans.
- There was a hospital-wide diabetes specialist nurse in place who provided support and training for staff across the medical services. Records showed the diabetes specialist nurse carried out 1751 inpatient reviews and 678 telephone reviews between January 2015 and September 2015.

Seven-day services

- Staff rotas showed that nursing staff levels were appropriately maintained outside normal working hours and at weekends to meet patients' needs.
- We found that sufficient out-of-hours medical cover was provided to patients by junior and middle grade doctors as well as on-site and on-call consultant cover. At weekends, newly admitted patients were seen by a consultant, and existing patients on the wards were seen by the ward-based doctors or the registrar.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. Physiotherapy support was also available on the wards during the day on Saturdays and Sundays to facilitate patient discharges.
- The hospital's biochemistry laboratory services were only available until 6pm during weekdays. There were arrangements in place with a local NHS trust to provide this service during out of hours and on weekends.
- The ward staff told us they received good support from the external biochemistry service on the weekends. A business case had been submitted to review the feasibility of running a seven-day biochemistry service within the hospital.

Medical care

- Dietitian support was available during weekdays but not on weekends. The medical staff were able to assess and treat patients identified with nutrition or hydration risks during the weekends.
- The ward staff told us they received good support outside normal working hours and at weekends.

Access to information

- Information such as daily nursing records were kept at the patient's bed side on paper records. However, the majority of patient information, such as patient histories, care plans, assessments and test results were accessible through the electronic patient record system.
- The electronic records system had been developed in-house and could be customised to enable staff to extract data needed for reporting and quality monitoring activities. This meant that staff could access all the information needed about the patient at any time.
- All the ward-based staff spoke positively about the access and usability of the hospital's IT systems. Ward staff told us requests for tests and scans were promptly responded to and test results were easily accessible.
- Electronic notice boards detailed information relating to staffing levels and identified patients with specific needs. Information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected.
- Staff could access information such as policies and procedures from the hospital's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Patient records showed that consent had been obtained from patients or their representatives and that planned care was delivered with their agreement.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).
- There was a hospital-wide safeguarding lead that provided support and guidance for staff for mental capacity assessments, best interest meetings and DoLS

applications. The safeguarding lead was accessible, visible on the wards and involved in the majority of cases where capacity assessments or DoLS applications were required.

- If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative) that could legally make decisions on the patient's behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals. We saw evidence of this in the patient records we looked at.
- Patient records showed that staff carried out mental capacity assessments for patients that lacked capacity to make an informed decision about their treatment. We looked at three patient records where a DoLS application had been made and the records for this had been completed correctly.

Are medical care services caring?

Outstanding



We rated the medical care services at The Christie Main Site as 'Outstanding' for being caring. This was because: -

- We spoke with 10 patients and the relatives of another five patients. We also received comments about the services as part of our listening event. They all spoke very positively about the care and treatment they received. Patients and their relatives were overwhelmingly positive about the care and treatment provided.
- We observed staff across the medical wards and saw patients were consistently treated with dignity, compassion and empathy. Patients and their relatives were very complimentary and full of praise when describing the care and support they received from the staff across the medical services.
- We made observations about the care people received and carried out a Short Observational Framework for Inspection (SOFI). Throughout our observation we saw excellent interactions between staff and patients. Staff interaction was kind, compassionate and very caring. Staff frequently engaged with the patients and their discussions with patients were friendly and sincere.

Medical care

- Patient feedback from the NHS Friends and Family Test between February 2015 and January 2016 showed the medical wards consistently achieved scores of 95% to 100%. This indicated that most patients were highly positive about recommending these wards to friends and family.
- The cancer patient experience survey (CPES) 2013/14 showed the trust was rated in the top 20% of trusts for nine of the 34 questions. The CQC's adult inpatient survey 2015 showed that the trust was rated as 'better' when compared with other trusts for nine out of the 10 questions.
- Patients and their relatives were kept fully involved in their care and kept informed about their treatment. Patients could contact the services at any time for advice and support if experienced any problems at home.
- Patients were supported with their emotional and spiritual needs and were able to voice any concerns or anxieties. All the patients and their relatives we spoke with spoke very positively about how staff consistently met their personal and emotional needs. They gave examples of how staff went beyond expectations to provide support; ranging from how their privacy and dignity was maintained to how staff consistently took the time support and encourage them when they were upset.

Compassionate care

- We saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner in the medical wards.
- Patients' bed curtains were drawn when providing care and treatment and staff spoke with patients in private to maintain confidentiality.
- During our inspection, we made observations about the care people received and carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may not be able to talk with us. We followed the care of three patients within the oncology assessment unit (OAU). This helped us to understand their experiences of the care and treatment they received.
- Throughout our observation we saw excellent interactions between staff and patients. Staff interaction

was kind, compassionate and very caring. Staff frequently engaged with the patients and their discussions with patients were friendly and sincere. The nurses and medical staff took time to explain what they were doing and took into account the patient's preferences. Staff conversations with patients were detailed and the patients appeared to be fully engaged and in a positive mood throughout the interactions with the staff.

- We spoke with 10 patients and the relatives of another five patients. They were very complimentary towards the staff and gave us very positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included: "staff have made things as easy as possible", "fantastic, treated with compassion, nothing too much trouble for the staff" and "couldn't have been treated any better from the porters to the top consultants everyone is phenomenal".
- We also received comments from 88 patients and relatives as part of our listening event. This included approximately 38 comments about the medical services. All the comments were overwhelmingly positive about the care and treatment provided and patients and their relatives were very complimentary and full of praise when describing the staff at the hospital.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between February 2015 and January 2016 showed the medical inpatient wards consistently achieved scores of 95% to 100%. This indicated that most patients were positive about recommending these wards to friends and family.
- The average response rate (the percentage of patients that completed the survey out of all eligible patients) was also better than the England average of 33.7% across the medical wards.
- The cancer patient experience survey (CPES) 2013/14 showed the trust was rated in the top 20% of trusts for nine of the 34 questions. This included patient's rating of care 'excellent' / 'very good', always treated with respect and dignity by staff, patient given a choice of different types of treatment, nurses did not talk in front of patient as if they were not there and the patient had confidence and trust in all ward nurses.
- The CPES survey showed the trust was rated in the middle 60% of trusts for 21 questions.

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- The survey results showed patient's responses were positive in relation to most aspects of their hospital stay and the negative rated question responses did not relate directly to the patient's stay in the hospital's medical wards.
- A review of data from the CQC's adult inpatient survey 2015 showed that the trust was rated as 'better' when compared with other trusts for nine out of the 10 questions and 'about the same' for one of the questions. The results were on 676 responses received from patients.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand. Staff were respectful and sought permission from patients before they delivered care or treatment.
- Patients and their relatives spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment. A patient told us they received good advice in relation to managing swollen feet, including advice on how to elevate their feet, advice on diet and how to keep warm.
- Patients and their relatives told us they were kept informed about their treatment. Patients told us the nurses asked them if they needed any support each time they passed by.
- A patient told us if they experienced any problems at home they could contact the wards during normal hours or the helpline during weekends and out-of-hours service.
- Relatives told us they were able to arrange visiting times based on their preferences.
- Most wards had a ward hostess in place that routinely went around to each patient and offered drinks and snacks to them and their relatives. One patient described their hospital experience as "like a hotel".

Emotional support

- The staff we spoke with understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to

patients. A patient on bed rest told us they felt embarrassed about their toileting needs and the nurses had put them at ease and maintained their privacy and dignity.

- Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties. A patient told us when they felt upset the staff would sit and talk with them to make them feel comfortable.
- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that the patient or their relatives were able to voice any concerns or anxieties. Teenage and young adults were assigned a key worker for additional support and advice during their hospital stay.
- Each area had relative's rooms where discussions could take place in private. Patients and their relatives told us the medical staff were approachable if they needed to discuss their care and treatment. One relative told us they were given bad news truthfully, sensitively and in plain language. They felt the manner in which this was communicated was respectful and supportive.
- Staff were able to provide patients and their relatives with information about chaplaincy services and bereavement or counselling services.
- Patient's relatives were also provided with a bereavement booklet if needed. Staff told us they were supported by the hospital's SCT for support and advice during bereavement. There was a multi-faith prayer room in the hospital.

Are medical care services responsive?

Outstanding



We rated the medical care services at The Christie Main Site as 'Outstanding' for being responsive to patient's needs. This was because: -

- There was a holistic and person-centred care approach to the delivery of care for patients across all age groups. We saw positive examples where patient's individual needs were met, such as patient activities that were planned and based on their personal preferences.

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- Patients and their carers were offered a range of complimentary therapies free of charge. These services were widely available across the medical services and patients and their relatives spoke positively about their availability and accessibility.
 - Patients were also offered two services called 'Look good, Feel Better' and 'Colour Me Beautiful' to promote self-esteem and to help them cope with the impact of changes to their body image, such as hair loss due to treatment.
 - Patients and their relatives were offered a food voucher to use in the hospital's canteen if they did not like the food offered on the regular ward menus.
 - There were systems in place to support vulnerable patients, such as patients living with dementia or a learning disability. The environment and facilities for teenage and young adult patients were age-appropriate and provided a broad range of recreational activities.
 - Services were planned and delivered to meet the needs of local people. Patients were admitted and discharged from the services in a timely manner. Daily bed management meetings took place to address any issues relating to patient flow. There was sufficient bed space in the wards so patients could be appropriately cared for.
 - The services consistently achieved the 18 week referral to treatment standards and the 31-day and 62-cancer wait time standards during 2015/16. The rate of delayed discharges based on the proportion of occupied bed days per month ranged between 0.3% and 1.8% from April 2015 to March 2016. This meant most patients were discharged in a timely manner.
 - There were 21 complaints raised across the medical care services between March 2015 and February 2016 and these were investigated and responded to in a timely manner. Complaints about the services were shared with staff to aid learning.
- Service planning and delivery to meet the needs of local people**
- The hospital provided a range of elective and unplanned medical services for patients across the country. This included clinical oncology, medical oncology, endocrinology, clinical haematology and brachytherapy.
 - Hospital episode statistics data showed there were 14,144 admissions at the hospital between September 2014 and August 2015. The data showed that 26% were emergency admissions, 24% were elective admissions and 50% of admissions were day cases.
 - Medical oncology patients accounted for 43% of admissions, followed by clinical oncology (32%) and clinical haematology (18%).
 - The haematology and transplant unit at the hospital was one of the largest centres across the country and had approximately 1800 inpatient / day case episodes per year.
 - The endocrinology unit was a nurse-led day case unit that managed the whole patient journey from investigation and diagnosis. There were 6698 dual energy X-ray absorptiometry (DEXA) scans undertaken on the unit during 2015/16. A DEXA scan is a special type of X-ray that measures bone mineral density.
 - The Palatine ward was an integrated inpatient facility for adult haematology patients and teenage and young adult (TYA) oncology patients.
 - It had specifically designed areas for TYA patients aged 16 to 24 years alongside inpatient treatment and care for adult haematology patients, over the age of 25. The ward was a day case clinical area for post general anaesthetic recovery of children undergoing radiotherapy.
 - The ward also provided high-efficiency particulate arrestance (HEPA) filtered accommodation for up to 12 patients having high dose chemotherapy; and bone marrow transplants for leukaemia, lymphoma and solid tumours of all ages over 16 years.
 - We saw that patients aged under 16 years received care from paediatric-trained nursing and medical staff and there was appropriate segregation from the adult areas.
 - There were daily meetings with the bed management team so patient flow could be maintained and to identify and resolve any issues relating to the admission or discharge of patients.
 - The areas we inspected were compliant with same-sex accommodation guidelines, we observed that males were cared for in separate areas to females. There were no mixed sex accommodation breaches reported between April 2015 and March 2016.

Access and flow

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- We did not highlight any concerns relating to the admission, transfer or discharge of patients from the medical wards. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- The planned admissions and transfer (PAT) suite unit operated on weekdays from 8am until 8pm (Fridays until 7pm). Staff on the unit were supported by ANP's that carried out emergency assessments and supported patient discharges.
- The PAT unit provided care for elective admissions prior to being admitted to an inpatient ward and care for radiotherapy patients transferred from other hospitals. The unit also provided other services such as blood transfusions and ascitic drains.
- There was a 24-hour telephone helpline service (hotline) for patients and carers for advice on the side effects and complications of cancer treatments, such as chemotherapy. Advice was given by nurse practitioners with consultant and registrar support if needed.
- The oncology assessment unit (OAU) had 20 inpatient beds and rapid access clinic bed (open Monday to Friday) to accommodate urgent and unplanned medical admissions to the hospital.
- Patients could be admitted to the OAU directly following an outpatient appointment, via the 24-hour hotline service or transferred from other hospitals. Patients requiring admission to the hospital were transferred to the hospital's wards from the OAU.
- Bed occupancy rates varied across the medical wards. Records between April 2015 and March 2016 showed average bed occupancy rates were; OAU (80%), ward 4 (91%), ward 11 (93%), ward 12 (91%) and Palatine ward (90%).
- The bed occupancy rates were higher than the overall hospital-wide bed occupancy rate of 82.6% during this period. The hospital's internal bed occupancy target of 82% had only been achieved in the OAU. This was reflected in the medical wards we visited as we found that most available beds were occupied.
- We did not see significant numbers of medical patients admitted to the surgical wards (medical outliers) during the inspection. We identified two medical patients that were located in the surgical wards. There were instances where medical patients were placed in other medical specialty wards due to capacity issues. However, the numbers we observed were not significant. For example, the lead nurse on the Palatine ward told us there had been six patients placed on wards 11 and 12 during the past week due to bed availability issues.
- The medical staff generated a daily list of names and locations of the patients they were responsible for from the hospital's web portal. We saw that medical patients placed in medical wards outside of their specialty were seen daily by doctors from within their specialty area.
- Records between February 2015 and January 2016 showed 7,734 patients (95.3%) did not move wards during their hospital stay and 382 (4.6%) had one or more ward moves following their admission. The overall number of patients that had one or more ward moves during their admission (382) had improved from 493 during the previous 12 months. Ward staff told us they avoided moving patients once admitted and one of the main reasons for bed moves was ward refurbishment activities.
- Staff completed a discharge checklist, which covered areas such as medication and communication to the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner. Discharge letters written by the doctors included all the relevant clinical information relating to the patient's stay at the hospital.
- Records showed 72 patients across the medical services experienced delayed discharges during 2015/16 (equivalent to 442 delayed bed days). This included 65 patients (90%) that had delayed discharges because they were waiting for hospice beds and four patients (5.5%) that were awaiting a nursing home placement.
- The rate of delayed discharges based on the proportion of occupied bed days per month ranged between 0.3% and 1.8% from April 2015 to March 2016. This showed the majority of patients were discharged from the medical wards in a timely manner.
- The referral to treatment (RTT) incomplete pathway standard is that at least 92% of patients should have to wait less than or equal to 18 weeks of referral for their treatment. Hospital records showed compliance against the incomplete pathway standard was 98.5% between April 2015 and March 2016 (i.e. 2015/16).
- In June 2015, NHS England abolished the RTT standard that at least 90% of admitted and non-admitted

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patients should start treatment within 18 weeks of their referral. Records showed the hospital achieved 98.6% compliance for non-admitted patients and 96% compliance for admitted patients during 2015/16.

- The NHS 31-day cancer waiting time standard is for at least 96% of patients who are newly diagnosed with a cancer to receive their first treatment within 31 calendar days from the date of the decision to treat. Hospital records showed compliance against the 31-day standard was 98.4% during 2015/16.
- During this period, the hospital achieved 99.8% compliance against the standard for at least 98% patients to experience a maximum wait of 31 days for a second or subsequent anti-cancer drug treatment.
- The NHS 62-day cancer waiting time standard is for at least 85% of patients who are urgently referred by their GP with a suspicion of cancer and are subsequently diagnosed with cancer should wait no longer than 62 calendar days from the date the referral is received by the hospital to the date of their first treatment. Records showed compliance against the 62-day standard was 88.5% during 2015/16.
- During this period, the hospital achieved 88.0% compliance against the standard for at least 80% patients to experience a maximum wait of 62 days following a consultant's decision to upgrade a patient's priority.
- The hospital also achieved 97.6% compliance against the standard for at least 90% patients to experience a maximum wait of 62 days for first treatment following referral from an NHS cancer screening service during 2015/16.

Meeting people's individual needs

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- The medical wards had notice boards displaying photographs of the staff working that particular shift so patients and relatives could identify staff when needed.
- Staff could access a language interpreter if needed.
- The areas we inspected had dementia link nurses in place. Staff also used a 'passport' document for patients admitted to the hospital with dementia or a learning disability. This was completed by the patient or their representatives and included key information such as

the patient's likes and dislikes. The ward staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.

- There was a hospital-wide Macmillan Dementia Nurse Consultant that provided staff with guidance and support when caring for patients with dementia. Staff could also contact the hospital-wide safeguarding lead for advice and support for dealing with patients with learning disabilities.
- Staff could access appropriate equipment, such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the medical wards.
- Patients across the medical services were offered a range of complimentary therapies (such as massage, aromatherapy, acupuncture, reflexology, therapeutic touch, hypnotherapy, creative visualisation and smoking cessation and alcohol advice) for patients free of charge. These services were available during weekdays and were also offered to the carers or relatives of patients.
- Patients were also offered two services called 'Look good, Feel Better' and 'Colour Me Beautiful' to promote self-esteem and to help patients cope with the impact of changes to their body image, such as hair loss due to treatment. The services were provided by volunteers and are managed by the cancer information centre staff.
- The patients and relatives we spoke with routinely used the services and spoke positively about the access and availability of these services.
- Patients across the medical services received daily support from a team of volunteers. The support included talking with patients, supplying newspapers and accompanying patients to other parts of the hospital.
- Patients across the medical services were offered a food voucher to use in the hospital's canteen if they did not like the food offered on the regular ward menus. This voucher was also made available to relatives of patients that stayed in the hospital for extended periods of time. Patients and their relatives were also offered ready meals and snacks during out-of-hours service.
- The Palatine ward routinely carried out workshops with teenage and young adult patients. The Christie crew

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youth coordinators were involved in engagement activities and arranging activities and events (such as external trips) for teenage and young adult (TYA) patients.

- Staff involved patients in the design of the ward's decor (such as graffiti art) to make the ward environment age appropriate. TYA patients had access to facilities such as a music room and an activities room (including pool table and games consoles). TYA patients admitted to the hospital were asked to complete an activities questionnaire so person-centred activities could be arranged based on the patient's own preferences.
- Staff on the Palatine ward arranged a 'pizza and movie' night each week and this was popular with teenage and young adult patients on the ward.
- There were facilities for overnight accommodation for the relatives of patients. The Palatine ward had six overnight rooms that were offered to patient's relatives.

Learning from complaints and concerns

- The areas we inspected had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the staff.
- The senior medical and nursing staff were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team.
- Staff told us that information about complaints was discussed during daily 'safety huddles' and at routine staff meetings to aid future learning. We saw evidence of this in the meeting minutes we looked at.
- The complaints policy stated that complaints would be acknowledged within two working days and investigated and responded to within 25 working days for routine formal complaints. For complex complaints, the timescales for responding were agreed with the complainant to allow sufficient time to investigate the complaint.
- Records showed there were 21 complaints raised across the medical services between March 2015 and February 2016. The most frequent reasons for complaints were due to 'communication / information to patients' and 'attitude of staff'.

- The average time taken to respond to these complaints was 47 days. This meant the majority of complaints about the medical services were responded to in a timely manner, but not always within the timescales specified in the hospital's complaints policy.

Are medical care services well-led?

Outstanding



We rated the medical care services at The Christie Main Site as 'Outstanding' for being well-led. This was because:

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- The hospital's vision and values had been cascaded across the medical services and staff had a clear understanding of what these involved. Key risks to the services, audit findings and quality and performance was monitored through routine departmental and divisional governance and quality meetings.
- There was effective teamwork and clearly visible leadership within the services. Staff were positive about the culture within the medical services and the level of support they received from their managers. There were low levels of staff sickness and turnover rates across the medical services, which indicated there was a positive culture within the hospital.
- There was routine public and staff engagement and actions were taken to improve the services. There was involvement in innovative research and clinical trials programmes in order to improve the care and treatment provided for patients.
- The trust had one of the largest clinical trials portfolios in the country, with over 550 active clinical trials. The trust was named, by the National Institute for Health Research (NIHR), as one of the best hospitals providing opportunities for patients to take part in clinical research studies.

Vision and strategy for this service

- The hospital's 20:20 vision was based on four principles: 'leading cancer care', 'the Christie experience', 'local and specialist care' and 'best outcomes'.

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- The 'Christie Commitments' outlined the hospital's values and these were based on achievement and recognition, learning and development, healthy workplace, communication and engagement and being proud of the Christie
- The strategy for medical services had been incorporated into the trust's strategic plan 2014-2019. This listed specific objectives including demonstrating the best clinical outcomes and patient safety, patient experience and clinical effectiveness, to be an international leader in research and innovation, to maintain excellent operational and financial performance and to be an excellent place to work and attract the best staff.
- The vision, values and objectives had been cascaded to staff across the medical services and staff had a good understanding of these.
- The majority of the medical services provided at the hospital were part of the networked services division. The overall lead for the networked services was the deputy chief operating officer, who was supported by the divisional director.
- The oncology assessment unit and planned admissions and transfers (PAT) suite formed part of the cancer centre services division.
- The medical services were divided into clinical directorates based on specific specialties and each speciality had a clinical director, a matron and a service manager. The medical wards were led by ward managers that reported to the matrons.
- The ward based nursing, support and medical staff we spoke with told us they understood the reporting structures clearly and described their line managers as approachable, visible and who provided good support.

Governance, risk management and quality measurement

- There were monthly quality and governance meetings, monthly integrated performance meetings and monthly departmental staff meetings across the medical services. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- Risks were documented and escalated by the service appropriately. Each department maintained their own local registers and any significant risks were escalated to the corporate risk register. We looked at the departmental risk registers and these showed that key risks had been identified, assessed and were being reviewed on a monthly basis by the departmental clinical leads and matrons.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that routine audit and monitoring of key processes took place across the wards to monitor performance against objectives and this was discussed during routine meetings and results were displayed on notice boards in the areas we inspected.

Leadership of service

Culture within the service

- All the staff we spoke with were proud, highly motivated and spoke positively about the care they delivered. Staff told us there was a friendly and open culture. They told us they received regular feedback to aid future learning and that they were supported with their training needs by their managers.
- Staff spoke positively about the organisational support they received. For example, services for patients such as 'look good, feel better' and complimentary therapies were also made available for staff at a discounted rate. We spoke with two volunteers and they spoke positively about the support they received from ward staff.
- The levels of staff sickness and turnover rates across the medical services showed there was a positive culture within the hospital.
- Records showed the average sickness rate for staff across the networked services division was 3.3% between April 2015 and March 2016. The sickness levels were within the hospital's target of below 3.4% and also better than national averages during this period.
- The staff turnover rate across the hospital ranged between 10.33% and 15.72% between April 2015 and March 2016.

Public engagement

Medical care

- Staff across the medical services told us they routinely engaged with patients and their relatives to gain feedback from them. The ward managers and matrons told us they sought feedback from patients through daily walk rounds.
- The oncology assessment unit recently developed an 'ideas tree' where patients and their relatives could make suggestions on how the services could be improved.
- Patient feedback was obtained formally through participation in patient feedback surveys and ad hoc patient focus groups.
- Patient satisfaction survey results across the hospital for each month between April 2015 and March 2016 showed that patient feedback was consistently highly positive (98.6% to 99.7%).
- As part of the council of governor's initiative, the hospital's governors sought feedback from patients. Patient feedback between August 2014 and July 2015 was mostly positive and the governor's findings were shared across the hospital.

Staff engagement







- Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the areas we inspected. The trust also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- The medical and nursing staff participated in ad hoc training days included that included engagement, training and discussions around improvements to clinical processes.
- The NHS staff survey 2015 showed the trust performed better than the national averages for 11 indicators. The overall staff engagement score for the trust was 4.03, which was better than the national average score of 4.01 for specialist acute trusts.

- Members of the senior executive team carried out routine scheduled walk rounds to engage with patients and staff across the hospital, including the medical services.

Innovation, improvement and sustainability

- The trust was named, by the National Institute for Health Research (NIHR), as one of the best hospitals providing opportunities for patients to take part in clinical research studies.
- The trust had one of the largest trials portfolios in the country, with over 550 active clinical trials. The haematology research team ran four clinical trials with an investigational transplant regimen and a further eight trials with a transplant included as part of the protocol during 2014/15. The endocrine unit had 15 research trials on-going (involving 231 patients in open studies) and a further nine trials in set-up.
- The Christie School of Oncology was established to provide undergraduate education, clinical professional and medical education and this was one of the first its kind nationally.
- The European Society for Blood and Marrow Transplantation (EBMT) and the International Society for Cellular Therapy (ISCT) established the Joint Accreditation Committee - ISCT & EBMT (JACIE) in 1998 for the purposes of assessment and accreditation in the field of haematopoietic stem cell (HSC) transplantation. The hospital's stem cell transplant programme achieved re-accreditation with JACIE standards during May 2016.
- The matrons and clinical leads across the medical services were confident about the future sustainability of the services. They felt there was a stable, skilled and committed workforce that provided a good standard of care and treatment.

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

Information about the service

The directorate of surgery at The Christie NHS foundation trust carry out a range of specialist cancer surgical procedures. These are usually highly specialised and complex procedures which are commissioned by the NHS specialised commissioning team. The surgery is divided into four specialisms; urology, gynaecology, plastics and colorectal. Hospital episode statistics data (July 2014 to June 2015) showed 4,219 patients were admitted for surgery at the hospital of which 63% had day case procedures, 34% had elective surgery and 3% were emergency surgical patients.

There are three surgical wards, a pre-operative assessment clinic and five operating theatres. The department carried out urgent surgery as well as day case and elective surgery procedures.

As part of the inspection, we inspected the operating theatres, recovery areas, wards 1 and 10 (inpatient surgical wards), the day surgery unit and the pre-operative assessment clinic.

We spoke with 17 patients and carers and looked at 21 patient care records. We spoke with 48 staff of different grades including nurses, doctors, allied health professionals, domestics, support workers, surgeons, managers, surgical department leads, administrators and matrons. We received comments from our listening events and from people who contacted us to tell us about their experiences. We observed care and treatment, reviewed

performance and assessed information about the surgical directorate. We inspected the environment to determine if it was an appropriate setting for delivering care and treatment and for use by patients and staff.

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Summary of findings

We rated surgery services as 'Outstanding' overall. This was because:

- There had been no serious incidents or never events from February 2015 to March 2016.
- There was a good culture of openness, reporting and investigation of incidents. There was evidence of positive improvements and changes made as a result of incidents. Learning was identified from investigations and this was disseminated and shared with staff to prevent future occurrences.
- The environment was clean and hygienic, with low levels of healthcare associated infection and high levels of harm free care.
- There were robust systems in place for the safeguarding of vulnerable patients. There were good safeguarding training rates and staff were aware of their responsibilities and the correct procedures to follow.
- Surgical and nurse staffing levels were good and compliance with mandatory training was satisfactory.
- Care and treatment for the deteriorating patient was suitable with good support from the critical care and outreach teams. Patient risk was assessed and monitored by effective pre-operative procedures and effective risk assessing.
- Care and treatment was provided which followed relevant National Institute for Health and Care Excellence (NICE) guidance and best practice. Surgical procedures were conducted with respect to current evidence, studies and advice and the directorate was a leading exponent of new and innovative techniques which were adopted as best practice nationwide and further afield.
- Holistic attention was paid to the nutrition and hydration needs of patients.
- Pain was recognised, monitored and treated promptly and effectively. Patients said they were happy with the levels of pain control.
- Surgical outcomes were positive; data and statistics regarding mortality, complications, survival rates, quality of life and functionality recorded positive outcomes. High numbers of patients were involved in clinical and surgical trials.
- Staff were competent, experienced and well trained and there was a lot of support and encouragement for further personal and professional development. Appraisal rates were very good.
- There were excellent examples of multidisciplinary working, which was coordinated and comprehensive. Collaborative working between disciplines, directorates and other healthcare organisations was evident and effective.
- There was adequate access to consultant care, diagnostics, key services and reviews across the seven days of the week.
- We found a strong person centred culture with holistic care provided by highly motivated kind and caring staff who went the extra mile to care for their patients.
- We found that patients were active partners in their care and were engaged in decisions and direction of their care.
- Patients' emotional and social needs were highly valued by staff and this was embedded into their plan of care. There was a wide range of complementary therapies, emotional support, social wellbeing and psychological services available to patients.
- Patients' individual differences were recognised and accommodated without judgement or discrimination. Reasonable adjustments were made and care was tailored for individual needs.
- Feedback from people who used the service was continuously positive regarding the way they were treated by staff. They believed that staff went above and beyond their role in the way they care for their patients.
- There was a holistic and person-centred care approach to the delivery of care for patients across

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all age groups. We saw positive examples where patient's individual needs were met, such as patient activities that were planned and based on their personal preferences.

- A wide range of complementary therapies, wellbeing and support services were provided to patients and their carers, most of which were free of charge. These services were widely available and accessible to surgical patients pre and post operatively and were very well received and valued by those using the service.
- The surgical directorate at the Christie offered specialised bespoke surgical treatments to patients with unusual, complex and advanced cancers, many of whom had been told no treatment was available.
- The services were planned and delivered to meet the needs of local people and the needs of those from further afield. The facilities and environment were generally suitable for the provision of the services it delivered.
- There was good access and flow with good referral to treatment times, low rates of delayed transfers of care and discharges and low levels of cancelled operations.
- There were low rates of complaints and those complaints were investigated fully with positive outcomes made from recognition of areas for improvement.
- The directorate had a high level of satisfaction across all staff groups. There was a tangible, extremely positive culture amongst staff and they were proud of their organisation and the service they provided.
- The Christie commitment pledges provided consistently high levels of engagement with staff. The leaders inspired staff involvement and collaboration in innovation, improvement and raising standards. Staff were motivated and driven and fully committed to trust and directorate shared goals.
- The organisation took steps to improve the health and wellbeing of their workforce by considering their holistic needs. They offered psychological

counselling and debriefs, welfare advice including financial and legal consultations, complementary therapies and relaxation therapies and use of the art room to assist with mental wellbeing.

- The surgery directorate and trusts hospital's vision and values were to become the national leading proponent of cancer services and a recognised player on the world stage. This vision and strategy was cascaded and embedded across the surgery directorate. Staff had a clear understanding of what this involved and their role in that strategy.
- The directorate was aware of key risks to service provision, they used quality and performance data and audit findings to monitor and act upon challenges and opportunities through trust and divisional governance and team meetings. They benchmarked themselves against national and international standards and compared favourably to surgical outcomes and standards.
- The leadership sought continuous improvement and innovation in the surgical procedures they delivered. The directorate was always looking for innovative ways to improve treatments for patients and endeavoured to become a world leader in cancer surgery. There was heavy involvement in research and clinical trials programmes in order to improve the care and treatment provided for patients.
- The Christie was a national leader in cancer research including driving forward new surgical techniques and collaboration with other disciplines to develop novel combination treatments and reporting outcomes to share knowledge with others.
- The surgical directorate gather feedback and outcomes from their pioneering surgeries to produce research publications to share outcomes and feedback information to research organisations such as Cancer Research UK. The surgical directorate worked in collaboration with other healthcare providers both locally and nationally through the vanguard projects, through provision of cancer services in local NHS trusts and through the sharing of advice and expertise by acting as a centre of excellence and point of contact for cancer treatment and procedures.

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- The directorate sought feedback from service users from various equality groups in order to assess performance ensure equality in hard to reach, minority and underrepresented groups.

However:

- We found that the trust policy concerning the disposal and 'wasting' of controlled drugs, where the full contents of a vial was not prescribed and administered was not being consistently applied in theatres and recovery, some staff recorded waste and some did not within the same book.
- We found the operating theatres to be only partially compliant with the National Patient Safety Agency (NPSA) 'five steps to safer surgery' and the completion of the World Health Organisation (WHO) checklist. We found the process was lacking in some areas as not all team members were present at the briefing and they did not complete the time out introductions correctly. The directorate did not undertake the WHO documentation audit.
- We found that in theatres some staff did not wear gloves when in direct contact with a patient and masks were not always worn during insertion of a central venous catheter (CVC).
- We found that 4 out of 17 patients records contained illegible sections within surgery consent forms.
- We found the temporary environment of a portacabin being used for the delivery of a pre-operative assessment clinic was unsuitable, it was cramped and unwelcoming. It did not ensure the privacy of patients was protected in the reception area. We also found that patients notes were left unattended in a public area in the pre-operative assessment clinic, and two diaries containing patient information were also left unattended on the reception desk.
- We found that the directorate had an inconsistent approach to the application of the Mental Capacity Act 2005 and the assessment of a patient's capacity to consent to surgery and treatment.

- 45% of formal written documentation of consent for procedures was gained by staff without competency based training qualifications in gaining consent.
- The trust was not fully compliant with all of the recommendations in the 'Implementation of the Faculty of Pain Medicine's Core Standards for Pain Management (2015)'.

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Are surgery services safe?

Requires improvement



We rated surgery services as 'Requires Improvement' for safe. This was because:

- We found that the trust policy concerning the disposal and 'wasting' of controlled drugs, where the full contents of a vial was not prescribed and administered was not being consistently applied in theatres and recovery, some staff recorded waste and some did not within the same book.
- We found the operating theatres to be only partially compliant with the National Patient Safety Agency (NPSA) 'five steps to safer surgery' and the completion of the World Health Organisation (WHO) checklist. We found the process was lacking in some areas as not all team members were present at the briefing and they did not complete the time out introductions correctly.
- The directorate did not undertake a documentation audit in line with best practice guidance.
- We found that in theatres some staff did not wear gloves when in direct contact with a patient and masks were not always worn during insertion of a central venous catheter (CVC).
- We found that 4 out of 17 patients records contained illegible sections within surgery consent forms.
- We found the temporary environment of a portacabin being used for the delivery of a pre-operative assessment clinic was unsuitable. We also found that patients notes were left unattended in a public area in the pre-operative assessment clinic, and two diaries containing patient information were also left unattended on the reception desk.

However we also found:

- They had had no serious incidents or never events from February 2015 to March 2016.
- There was a good culture of openness, reporting and investigation of incidents. There was evidence of

positive improvements and changes made as a result of incidents. Learning was identified from investigations and this was disseminated and shared with staff to prevent future occurrences.

- The environment was clean and hygienic with low levels of healthcare associated infection and high levels of harm free care. Statistics showed that they performed better than similar providers in terms of the safety thermometer data.
- There were robust systems in place for the safeguarding of vulnerable patients, there were good safeguarding training rates and staff were aware of their responsibilities and the correct procedures to follow.
- Surgical and nurse staffing levels were good and compliance with mandatory training was good.
- Care and treatment for the deteriorating patient was good with good support from the critical care and outreach teams. Patient risk was assessed and monitored by effective pre-operative procedures and effective risk assessing.

Incidents

- 'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. There were no reported never events for surgery at the trust from February 2015 to March 2016.
- There had been no serious incidents (STEIS) reported for the period February 2015 to March 2016.
- National Reporting and Learning System (NRLS) is a voluntary reporting tool, which captures, analyses and feeds back patient safety incident reports to the NHS. Reporting and analysis of safety related incident reports, including incidents resulting in no or low harm, provides an opportunity to reduce the risk of future incidents through learning.
- The surgery directorate reported 113 incidents to the NRLS between 1 February 2015 and 31 January 2016. 90 of these resulted in no harm, 22 in low harm and one resulted in moderate harm, there were zero reported incidents which resulted in severe harm or death.

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- 75.2% of incidents were reported to NRLS within 30 days and 97.3% of incidents within 90 days, which indicates a good response to reporting.
- Within the directorate's own internal reporting system, 470 incidents were reported for surgery between 1 April 2015 and 31 March 2016. The majority 461 resulted in no harm or minor harm. Seven incidents resulted in moderate harm, one in major harm and one in unspecified harm.
- As part of our inspection we examined nine incident reports and associated investigations and found that these were investigated appropriately, by suitably qualified and experienced staff, that contributing factors were highlighted and that action plans were put in place to help prevent any reoccurrence of these incidents.
- We found that information and learning from incidents was shared across the directorate of surgery via monthly team meetings, safety huddles, through the circulation of minutes of meetings and through newsletters and bulletins which were circulated electronically and posted on staff notice boards. We saw evidence of action taken to make tangible changes to practices where issues were identified following incidents.
- Surgical directorate mortality and morbidity meetings were undertaken every two months, however each specialism; urology, colorectal, plastics and gynaecology undertake their own meetings and undertake adverse clinical events (ACE) meetings to discuss issues of concern with the intention of learning from past experience. The minutes of such meetings were circulated within the directorate and were available on line or on staff notice boards. Key issues were shared within the surgery directorate and the whole trust if deemed appropriate and if lessons could be shared more widely.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We found that the 'duty of candour' regulations were being implemented appropriately following patient harm. We saw examples of this process and were satisfied that the process was in line with trust policy

and national guidance. Patients were invited to discuss issues with senior staff, they were kept updated on investigations and received an apology for the harm caused.

Safety thermometer

- The NHS Safety Thermometer is an assessment tool which measures a snapshot of harms once during the month (such as falls, pressure ulcers, bloods clots, and catheter related urinary infections).
- Safety thermometer information was displayed on a large television screen in a prominent place on the entrance to ward 10. It advised the numbers of falls, pressure ulcers, blood clots and catheter related infections identified on this ward. It also provided information on staffing levels, the friends and family test data and visiting hours.
- There was no display on ward 1 or the day surgery unit, we were advised that one was on order for ward 1 but it was delayed due to the ward moving location and being refurbished. No plans were in place for the day surgery unit.
- We found that the surgery directorate used the safety thermometer and dashboard information to monitor their own performance, identify areas they could improve and benchmark themselves against other wards and departments. The analysis of safety thermometer data also formed a part of the assessment process in the ward accreditation scheme.
- The trust had signed up to the NHS England 'open and honest care in your local hospital' initiative which published a monthly report on results from the safety thermometer, this was available to the public on the trust website.
- Information provided to Health and Social Care Information Centre showed that from May 2015 to April 2016 the trust reported 96.8% harm free care, this was better than the England average of 93.9. The Christie had higher (better) harm free care than other hospitals providing similar cancer specialist services for this period of time.

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- 1.6% of patients at the Christie were recorded as having a pressure ulcer compared with the England average of 4.6%. The Christie also had lower (better) rates than other hospitals providing similar cancer specialist services.
- 0.2% of patients at the Christie were recorded as experiencing a catheter related urinary tract infection, compared with the England average of 0.6%. The Christie also had lower (better) rates of than other hospitals providing similar cancer specialist services.
- 0.4% of patients at the Christie were recording as experiencing a fall, compared to the England average of 0.6%. The Christie also had similar or lower (better) rates of than other hospitals providing similar cancer specialist services.
- 1.1% of patients at the Christie were recorded as developing a blood clot or venous thromboembolism (VTE). This was higher than one hospital, but lower than the other hospitals providing similar cancer specialist services.
- We found some other infection control risks in the anaesthetic room; sterile instruments such as a laryngoscope, a catheter mount, face mask were opened in advance and were left on trays or on the anaesthetic machine, a bougie instrument was placed on top of the patient before being used. The sink drain in the anaesthetic room was cluttered with used items. Face masks were left face up on the anaesthetic machine posing an infection control and obstruction risk.
- We otherwise observed staff following infection control best practice in relation to waste management, disposal of sharps, contaminated waste and laundry.
- We found that equipment such as commodes and shower chairs were clean and labelled ready for use.
- On each ward there was a designated lead link nurse for infection prevention and control. These members of staff, had attended additional infection prevention and control training and were responsible for advice, training and the promotion of infection control in their area.

Cleanliness, infection control and hygiene

- During our inspection we found the surgical areas visibly clean and hygienic. We saw that cleaning rotas were in place.
- We observed staff working in surgical areas to be compliant with 'bare below the elbow' policies and compliant with trust uniform policy.
- There was adequate access to hand gels on entry to clinical and surgical areas and also at the point of care.
- Signage for those patients who were subject to isolation precautions were used to advise visitors and staff of the need to follow various precautions.
- On the whole we saw staff washing their hands and using hand gel between the delivery of care activities and they used appropriate personal protective equipment, such as gloves and aprons. However, in theatres we observed that five team members were not wearing gloves, we observed at least two of whom were in direct contact with the patient whilst not wearing gloves. We also observed that masks were not worn by staff for central venous catheter (CVC) insertion, which was contrary to the trust's own policy and wider best practice guidelines.
- Compliance with trust policy such as hand hygiene and infection control were monitored and audited regularly. Hand Hygiene audits for December 2015, January 2016 and February 2016 were 100% across the surgery directorate including wards 1 and 10, theatres 100%.
- The trust had an infection control team with infection control specialist nurses who were available to staff for training, advice and consultation.
- The infection control team undertook periodic environmental audits giving areas of improvement and action plans to achieve improvement. An audit in December 2015 found ward 10 was 98% compliant and raised actions to correct the non-compliant areas.
- The Christie had a total of 22 cases of Clostridium difficile (C diff) from April 2015 and March 2016, none of these cases were due to the infection being passed from patient to patient and four of these related to surgical patients on ward 10.
- The Christie had zero cases of MRSA from April 2015 and March 2016. In fact they have had no cases of MRSA in the previous year either.

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- The Christie did not undertake orthopaedic surgery and therefore did not contribute to the mandatory national surgical site infection (SSI) audits. However we did see that the trust follow 'saving lives guidance on surgical site infections and audited its performance. The last audit dated October 2015 showed the surgery directorate achieved 100% compliance in SSI prevention during all three stages of surgery.
- The directorate also achieved 100% compliance in the saving lives audits for peripheral line and central line insertion and care.

Environment and equipment

- We saw that there was a system for equipment servicing, testing and maintenance. However, we found that two defibrillators were out of date with their service regimen by two months. We were advised that there was a backlog with the on-site engineering department due to a member of staff leaving, but that the system was not back on course.
- We found that the ward and theatre areas were well maintained, free from clutter and provided a suitable environment for treating patients.
- However, we found the temporary environment of a portacabin on the road outside the main hospital was an unsuitable environment for the delivery of pre-operative assessment clinics. The space was cramped and uncomfortable, curtains were hanging off rails, there was little natural light and little privacy for patients in the reception and waiting area. Patients' records were left unattended.
- Staff in the theatres told us they almost always had access to the equipment and instruments they needed to meet patients' needs, but said sometimes there was delays in replacing faulty equipment as these had to go through a business case process.
- Waste and clinical specimens were handled and disposed of in a way that kept people safe. This included safe sorting, storage, labelling and handling.
- Other equipment such as commodes and hoists were found to be clean and maintained appropriately.
- The trust used single-use, sterile instruments as appropriate. The single use instruments we saw were

within their expiry dates. The service had arrangements for the sterilisation of reusable surgical instruments, some on site and some contracted out. We saw that this process was efficient and effective.

- Resuscitation equipment was checked in line with trust policy, trolleys they were locked, equipment was in date and records were kept of the unique seal reference numbers.
- Bariatric equipment was available to the wards and theatres if required.

Medicines

- We found that overall medicines, including controlled drugs and intravenous (IV) fluids were stored safely and in line with agreed protocols.
- We observed records that confirmed that staff carried out daily checks on controlled drugs and stocks to ensure medicines were reconciled correctly. During the inspection we also checked a random selection of controlled drugs on each ward and department and found the stock balances correlated with the registers. We also saw that the controlled drugs book showed evidence that two staff members had signed for controlled drugs.
- We found that trust policy concerning the disposal and 'wasting' of controlled drugs, where the full contents of a vial was not prescribed and administered was being followed on ward 1, ward 10 and the day surgery unit. However, this was not always being adhered to in theatres and recovery, some staff recorded waste and some did not within the same book.
- We found that medicines requiring cool storage were stored appropriately and records showed that refrigerators were being checked daily to ensure they were maintained at the correct temperature. We also found that room temperatures where medicines were stored were being checked appropriately, we saw that the room had become too high on two occasions and this had been escalated appropriately to the estates management team.
- A ward pharmacist was available daily Monday to Friday until 18.30 and via an on call system outside of these

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hours and at weekends. We saw that the pharmacist reviewed prescriptions and reconciled patients' admissions medicines and they ensured that records were correct up to date and medicines were available.

- Patients' drug allergies were noted prominently on patients' physical and electronic notes and a red wristband was worn by those with an allergy to emphasise this.
- The day surgery unit used patient group directive (PGD) prescription arrangements for common medicine administration. We observed that these were robustly documented and monitored. Competency assessments were undertaken and appropriate authorisations and reviews were undertaken and documented.
- The day surgery unit had an effective system for prescribing commonly used medicines post operatively for symptomatic relief. A doctor routinely prescribed a range of drugs in anticipation of common post-operative symptoms which the nurse was therefore able to administer without delay which assisted prompt symptomatic relief for the patient.

Records

- Patients' records were both electronic and paper based. The Christie had a bespoke in house electronic computer records system which was used by most departments, however some departments including pre-operative clinic and theatres wrote handwritten paper entries.
- As part of our inspection, we reviewed the records of 17 patients, we found that on the whole they were accurate, complete and up to date. However we found that four consent forms were illegible.
- We saw that the pre-operative clinic undertake a thorough and comprehensive pre-operative assessment of the patient.
- We saw that patients notes made at Christie contained the relevant risk assessments and patient allergy status. We saw care plans and pathways were completed thoroughly in nursing notes.
- On the wards patient notes were locked away securely to prevent unauthorised access and protect patient confidentiality. However, in the pre-operative assessment clinic, we saw that patients notes were left

in a trolley in an unattended reception area and two diaries with patient information were also left unattended on the desk. We also saw that porters came and delivered notes for future clinics and left them unattended in the reception area. We determined that this was common practice as when we pointed out the issue notes were moved but when we returned to the reception a short time later further sets of notes had been deposited in the trolley. We acknowledge that at the time of our visit the receptionist was absent due to sickness, however we also note that a receptionist is not scheduled to be present for the entire duration of the clinic and cannot be expected to have sight of notes for the entire duration of the clinic either, therefore we do not believe this is a satisfactory or secure way to manage patients confidential information.

Safeguarding

- All the staff we spoke with were aware of their responsibilities regarding safeguarding of patients and the correct procedures to follow; they could describe how to access the policy on the trust intranet and who to speak to for advice.
- The directorate had made a decision to refer all vulnerable patients such as those living with dementia or learning disabilities to the safeguarding specialist nurse for input and advice.
- Staff received annual mandatory safeguarding training updates for both children and young people and for vulnerable adults. Data from the trust showed that the surgical direct recorded 96% compliance with level 1 and level 2 children and young people and vulnerable adults safeguarding training. The trust had made the decision to roll out level 3 safeguarding training to all staff. Some staff had received this training and all others had been booked onto a course, this process would be complete within the following 6 months.
- The hospital had a specialist safeguarding nurse who was available Monday to Friday for advice and information. Outside of those hours, senior staff on duty were available for advice.

Mandatory training

- Mandatory training was kept updated by attendance on training courses or by training done remotely on a

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computer. The subjects classed as mandatory are those which are considered the most important such as basic life support, safeguarding patients and moving and handling.

- In the day surgery unit, 96% of staff had completed their mandatory training.
- In ward 10, 91% of staff had completed their mandatory training.
- In theatres, 94% of staff had completed their mandatory training.
- Any deficit was almost exclusively due to a recent decision that all staff should receive level three safeguarding which has not been fully rolled out yet. Otherwise departments would have achieved almost 100% compliance.

Assessing and responding to patient risk

- The surgery directorate effectively used the modified early warning system (MEWS) to identify sick and deteriorating patients who required closer attention. The patient's observations and vital signs produced a score, the higher the score the more urgent or sick was the patient.
- Sick patients whose MEWS scores reached 'trigger points' were reviewed by doctors on a time scale that was dependent on their score. There was an audit of compliance and completion of MEWS documentation in April 2015, which recorded ward 10 as being 100% compliant.
- In an emergency situation, an outreach team and emergency 'bleep holders' attended to treat the patient quickly.
- The outreach team was managed and provided from the critical care unit, they reviewed patients who scored high on MEWS and assessed if they required high dependency care. They also attended emergency calls and reviewed patients who had 'stepped down' from high dependency care to the wards.
- We observed the operating theatres to be only partially compliant with the National Patient Safety Agency (NPSA) 'five steps to safer surgery' and the completion of the World Health Organisation (WHO) checklist. We found the process was lacking in some areas by witnessing the processes during our inspection. We

found that during our observations on both occasions, the theatre team did not complete the introductions part of the briefing, they stated that it had already been done, however on both occasions the team composition had changed. We also found that all team members were not present for the briefing, which we noted had also been recognised as an issue on their most recent internal audit of compliance.

- Theatre managers reviewed compliance with the WHO checklist and NPSA 'five steps to safer surgery', through a six monthly observational audit, however we they did not undertake any documentation audit as recommended in the guidance 'How to Guide: Five Steps to Safer Surgery'.
- A 24 hour hotline telephone number was provided to patients upon discharge from surgical wards, this provided a point of contact for any concerns or issues following discharge. This hotline could arrange re-admission and further appointments or follow up as necessary.
- Patients' surgical risk was assessed at pre-operative clinic. Any potential risk were investigated and highlighted. Those at greater risk were referred to an anaesthetist for further assessment and advice if appropriate sent for further tests such as echocardiogram and lung function tests.
- The consultant surgeon and the anaesthetists would also review the patient on the morning of their surgery to ensure they were fit for surgery.
- Risk assessments were completed for manual handling, falls, pressure ulcers, nutritional needs and VTE. All of the risk assessments we reviewed were clear, legible and up to date. Each patient's individual risk assessments were completed and reviewed regularly.

Nursing staffing

- Nurse staffing was calculated, reviewed and audited bi-annually using a recognised patient acuity and dependency tool the 'safer nursing care tool (SNCT)'.
- The surgery directorate had only two nursing vacancies and sickness rates year to date as at December 2015 were 3.7% which was just short of the trust target of 3.5%, however the sickness rate at the time we visited was 6%.

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- Nurse handovers were conducted at shift changeovers where details about patient's needs, risks, plan and progress were discussed. Nurses were also represented at the multidisciplinary team handovers which update the wider team with patient care.
- We saw that actual staff numbers were very close to established numbers and there was sufficient staff to attend to patients, deliver care and keep them safe.
- During the three months before the inspection we saw that the planned level of registered nurses compared to actual level on duty was good, wards often had 100% fill rates and the lowest figure recorded was 93.5% of nurses. For care workers we also saw that figures were very close to 100%, however during April 2016 ward 10 had only 81.6% of their planned level of care workers on duty, this was very much again the normal trend and we were advised that if shifts were unfilled this was because managers had assessed patient acuity as low and deemed staffing levels to be safe.
- The directorate had a system for escalating issues regarding staffing numbers and systems were in place to ensure safe numbers were maintained.
- The staff on the surgical wards and in theatres were experienced, competent and knowledgeable in their area of work. Many members had worked at the Christie for many years and the turnover of staff was relatively low.
- The nursing staff did not use external agency staff, they had their own internal Christie nursing and staff bank. They only used experienced surgical nurses and support workers who currently worked or had worked on surgical wards.

Surgical staffing

- The surgical wards and theatres had adequate numbers of surgical staff with the appropriate mix of skills to ensure that patients were safe and received the right level of care.
- The surgery wards had daily consultant led ward rounds. During weekends a duty surgical would undertake the ward rounds. Where there was not a consultant physically on site, such as evenings and weekends they were readily accessible by telephone for

advice and support through an on call system, so there was always 24 hour consultant availability. This on call consultant was available to be on site within 30 minutes if they were required to be so.

- Out of hours surgical cover was provided by an arrangement with the medical out of hours doctors led by a medical registrar. Handovers were undertaken at shift changeover to ensure that incoming doctors were made aware of patients and their particular needs. The out of hours teams had access to surgical input from registrars and consultants.
- The directorate acknowledged they did not have enough surgical junior doctors to run a surgical out of hours rota. This issue was highlighted on the surgery risk register and as a response the directorate had decided to increase the numbers of advanced nurse practitioners and was currently training some and recruiting others with a view to providing 24 hours surgical cover independently of the medical wards. We found the out of hours staffing to be satisfactory.
- Junior surgical doctors and middle grade surgeons told us they felt supported by their consultants and they always had access to the advice and support they required. They said they had teaching and supervision sessions weekly and were encouraged and given an opportunity to develop their skills.
- We found there was some use of locum doctors, these locums were generally block booked and received an adequate induction process prior to practicing. They were given access to the computer systems and electronic records, online policies and procedures and the incident reporting system to ensure they were able to care for patients appropriately in the new environment.

Major incident awareness and training

- There was a documented major incident operational plan. This was to be put in place for any major incidents and emergencies such as terrorist threats, flood, fire or process management failures. However, the hospital is not a designated receiving hospital for casualties within the Greater Manchester overarching major incident plan.

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- There were also plans for business continuity, winter pressures, heatwaves, pandemic influenza and fuel shortages.
- The surgery directorate had completed a local business continuity plan as part of their input into the trust's major incident plan.
- All staff received emergency planning and awareness training on their corporate induction training days.
- Training on fire and bomb procedures were updated annually as part of the trusts mandatory training package.
- Emergency readiness drills and practices were conducted periodically.
- Staff were aware of the procedures to follow in the event of an emergency.
- Emergency surgery would be given priority over elective procedures in an emergency situation.

Are surgery services effective?

Good



We rated surgery services as 'Good' for effective. This was because:

- Care and treatment was provided which followed relevant National Institute for Health and Care Excellence (NICE) guidance and best practice. Surgical procedures were conducted with respect to current evidence, studies and advice and the directorate was a leading exponent of new and innovative techniques which were adopted as best practice nationwide and further afield.
- Holistic attention was paid to the nutrition and hydration needs of patients.
- Pain was recognised, monitored and treated promptly and effectively, patients said they were happy with the levels of pain control.
- Surgical outcomes were positive; data and statistics regarding mortality, complications, survival rates, quality of life and functionality recorded positive outcomes for patients.

- High numbers of patients were involved in clinical and surgical trials.
- Staff were competent, experienced and well trained and there was a lot of support and encouragement for further personal and professional development. Appraisal rates were very good.
- There were excellent examples of multidisciplinary working, which was coordinated and comprehensive. Collaborative working between disciplines, directorates and other healthcare organisations was evident and effective.
- There was adequate access to consultant care, diagnostics, key services and reviews across the seven days of the week.

However;

- We found that the directorate had an inconsistent approach to the application of the Mental Capacity Act 2005 and the assessment of a patient's capacity to consent to surgery and treatment.
- 45% of formal written documentation of consent for procedures was gained by staff without competency based training qualifications in gaining consent.
- The trust was not fully compliant with all of the recommendations in the 'Implementation of the Faculty of Pain Medicine's Core Standards for Pain Management (2015)'.

Evidence-based care and treatment

- The directorate followed relevant NICE guidelines and evidence based practice guidance in their care and treatment of patients.
- They undertook surgical procedures with respect to current evidence, studies and advice and were a leading exponent of new and innovative techniques which were studied and then adopted as best practice in other organisations.
- The surgery directorate complied with local policies and procedures and followed established integrated care pathways for individual procedures. Some of these pathways were initiated at pre-op clinic.

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- NICE guidance 'recognition of and response to acute illness in adults in hospital' (NICE clinical guideline CG50) and 'rehabilitation after critical illness' (NICE clinical guideline CG83) were followed within the surgery directorate.
- Enhanced recovery practices were used for a number of surgical procedures. Enhanced recovery is an evidence-based approach to surgery, which has been shown to help people recover more quickly after having surgery. The directorate had a dedicated enhanced recovery nurse and had relevant pathways and care plans in place.
- The directorate was one of only two sites in England who undertook cytoreduction surgery combined with hyperthermic intraoperative peritoneal chemotherapy; this was done in line with NICE interventional procedure guidance IPG331.
- The directorate adhered to their own local policies and procedures and undertook checks on compliance periodically.
- The directorate undertook local audit activity assessing their compliance with the Department of Health guidance 'Saving Lives: Reducing Infection, Delivering Clean Safe Care'. The audit covered monitoring their compliance with peripheral line insertion, central line insertion and surgical site infection precautions. The results showed 100% compliance with these policies and procedures.
- The directorate followed NICE quality standard QS3; 'venous thromboembolism in adults: reducing the risk in hospital', by completing VTE assessments and administering prophylaxis to help prevent blood clots.
- The directorate used technology and equipment to enhance the delivery of effective care and treatment. They used robots for surgical procedures which were shown to be more precise, less invasive, result in smaller wounds, decreased blood loss and pain and lead to a quicker healing and recovery time.
- The directorate use a pre-operative assessment process as per best practice and aim to get people as fit as possible for surgery by assisting with lifestyle changes and fitness advice.

- Theatres followed difficult airway society guidelines in theatres and difficult airway trolleys were present which displayed posters of algorithms to follow if required.

Pain relief

- The surgery directorate assesses pain as part of the modified early warning system (MEWS). The measuring of pain levels is integral to the MEWS scoring system.
- Patients were prescribed pain relief in keeping with the World Health Organisation 'analgesia ladder', which advocates an incremental approach to the administration of pain relief. Patients are asked for a score of their pain levels and they were given pain relief commensurate with these scores.
- Post-operative patients who were deemed suitable were given patient controlled analgesia (PCA) which they could control themselves by pressing a button to deliver pain relief. This had a time out function to prevent accidental overdose.
- Issues relating to post-operative pain relief were assessed at the pre-operative assessment clinic. Any potential issues were referred to the specialist pain team and anaesthetist for assessment and planning.
- The directorate had a pain focus group, who were looking at different ways of assessing pain for those patients who could not articulate their pain levels clearly. The group were taking steps to develop a tool to assess non-verbal behaviour to assist with determining if a patient was in pain and formulating an appropriate response to ensure that a person's pain was managed appropriately.
- The directorate undertook an audit of post-operative patients' pain control assessment, monitoring and treatment in October 2015. On the whole, this showed that patients were generally satisfied with the pain relief they received following their operation. 100% of patients said they were asked about their pain and were offered analgesia if they were in pain and 98% of patients were satisfied with their pain control. However, this also found that pain was not always discussed with patients before their operation and that patients were not always reassessed for their pain following administration of pain relief to check if this had been effective. An action plan had been put in place and had been reviewed following this audit.

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- The surgical wards had access to a dedicated pain team with specialist pain control nurses within core working hours. Out of hours and weekends, pain advice could be sought from the on-call anaesthetist.
- The directorate was not fully compliant with the 'Implementation of the Faculty of Pain Medicine's Core Standards for Pain Management (2015)'. They did not have specialist pain physiotherapists or psychologists as recommended, and only had one specialist pain consultant who undertook ward rounds on alternate weeks only.
- The patients we spoke with were satisfied that their pain was assessed and treated appropriately.

Nutrition and hydration

- The patient's records we checked included all appropriate assessments of nutritional requirements and those on fluid and food charts were completed regularly.
- Wards had access to a dietician with core hours who provided advice and input for those people who were highlighted to be at risk of dehydration or malnutrition. We saw evidence that this process was followed.
- Patients were routinely prescribed and given medication to prevent and treat nausea following surgery.
- The nutritional requirements of individual patients were highlighted during handovers, ward rounds and multi-disciplinary meetings to ensure a holistic approach to care. Those who were on fluid or food charts and those who needed assistance or encouragement with eating and drinking could be highlighted by notes above their bed.
- Surgical wards had access to a diabetes specialist nurse who was available for advice for patients and staff. Diabetic patients were allocated the first slot on theatre lists where possible and were monitored closely prior to and following surgery.
- Surgical ward had access to a dietician, who provided advice and input for those people who were highlighted to be at risk of dehydration or malnutrition.
- Patients told us they were happy with the quality and choice of food and that was provided.

- Patient who needed help with eating and drinking were assisted at meal times and throughout the day.
- Where possible patients who were able were encouraged to attend the dining rooms for their meals. There is evidence that using a dining area is not only a more favourable environment for eating, but has been shown to improve appetite and encourage better food intake than eating in bed.

Patient outcomes

- Hospital episode statistics data (July 2014 to June 2015) showed 4,219 patients were admitted for surgery at the hospital of which 63% had day case procedures, 34% had elective surgery and 3% were emergency surgical patients.
- The trusts major surgery 30 day survival rate from 1 January 2015 to 31 December 2015 was 100%.
- 17% of patients of the Christie were on a range of clinical trials. Patients who were on 'first human trials' were assessed and monitored by the critical care outreach team, who followed the patient through their inpatient stay.
- Patients who had been told that their cancers were inoperable in secondary care were often treated surgically at the Christie. The multidisciplinary cancer team could offer bespoke multi-speciality treatments, together with multi-modality therapy to patients which has been shown to improve survival rates and improve outcomes for patients.
- The national bowel cancer audit (2015) showed the trust performed better than the England average for adjusted 90 day mortality, adjusted two year mortality, adjusted 90 day readmission rates and data completeness; this is despite Christie patients being recorded as having more distant metastases. The Christie undertook less laparoscopic procedures 46% against an England average of 57% and 77% of Christie patients stayed in hospital longer than five days in comparison to 69% on average across England. The Christie excised 14 lymph nodes on average against an England average of 17.
- Data from the National lung cancer audit was not relevant as the surgery directorate did not undertake lung cancer surgery.

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- The national prostate cancer audit (2015) showed the trust achieved 100% for case ascertainment against an England average of 56% and performed better for Classification of Malignant Tumours (TNM) completion, but worse for ASA, PSA and Gleason score completion.
- The national emergency laparotomy audit 2015 showed that the trust achieved good compliance with best practice for final case ascertainment, CT scan before surgery, pre-operative review by consultant and anaesthetist, consultant and anaesthetist present in theatre. However, they performed less well regarding patients having a consultant surgeon review within 12 hours of emergency admission; risk being documented pre-operatively and assessments by specialist in older persons medicine.
- The directorate undertook 2658 day surgery procedures between July 2014 to June 2015.
- The directorate undertook 126 emergency procedures between July 2014 to June 2015. They did not have a 24 hour emergency theatre. If emergencies occurred 'out of hours' then on-call staff were called would attend within 30 minutes. If they occurred in core hours then emergencies took priority and theatre lists were rearranged.
- The average length of stay as an inpatient from January 2015 to December 2015 was 6.9 days which was within the trusts target. The average length of stay was longer than the England average, however comparisons are inconsequential due the unique patient group served at the hospital.
- The standardised relative readmission risk for surgical patients at the Christie was higher than the England average for elective procedures, but lower for elective procedures. However the readmission rate in the hospital was affected by the specialist nature of treatments provided and due to the complex needs of patients served.
- Theatre utilisation was 80.8% as at January 2016. This indicates that they used their operating theatre time effectively.
- The surgical directorate achieved improvements in peri-operative mortality at 30 days for colorectal surgery, this was 0.99% in 2013/2014 and was 0.55% for 2015/2015.
- The directorate undertook combination surgery and HIPEC therapy for Pseudomyxoma peritonei, this has improved survival rates and outcomes for patients. The survival rate at 60 months is approximately 90%, whereas non-combination surgery survival rate is 20% at 60 months.
- A United Kingdom gynaecological oncology surgical outcomes and complications(UKGOSOC) audit of 1669 gynaecological cancer procedures undertaken at 10 centres across the UK produced outcome data which provided a baseline average for such procedures. When compared to the Christie outcomes data this showed that the Christie had 45% less intra-operative complications, 57% less post-operative complications, 70% less returns to theatre and 12% less readmissions to hospital and whereas the audit found an average mortality rate of 1.9%, the Christies mortality rate was zero.
- The Christie has recorded at 50% survival rate at five years for their anal cancer patients, whereas the largest recorded study data of these patients recorded that zero percent (i.e. no patients) survived beyond 3 years in published data.
- Patients who had a radical cystectomy at the Christie have lower mortality rates than the England average and across many other treatment centres internationally.
- The use of state of the art surgical robots at the Christie has been shown to improve outcome through lower surgical margins for patients undergoing robot-assisted laparoscopic prostatectomy.
- The directorate has been instrumental in initiating changes to diagnosis and treatment of penile cancers, which has led to improvements in outcomes and reductions in complications.

Competent staff

- Annual appraisals give an opportunity for staff and managers to meet, review performance and development opportunities which promotes competence, well-being and capability. Trust data showed that 94.5% of the surgery staff group had received their annual appraisal; that is 94.5% of staff had received an annual appraisal in the last year as at January 2016.

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- Doctors in the trust undergo appraisals and supervision as part of their revalidation process. The trust had a designated responsible officer who ensured that processes were in place for all doctors to undergo annual appraisals. Such appraisals complied with national guidance and requirements and ensured there was satisfactory evidence that each doctor was suitable to be revalidated.
- The Christie and the surgical directorate provided specialist education and training for doctors and surgeons in specialist cancer surgery locally and nationally.
- Comparative outcomes by clinician were undertaken within the surgical directorate, this information was circulated monthly during directorate meetings.
- Junior doctors said there were good opportunities for development and skills acquisition in the surgical directorate and that their supervisors were encouraging and supportive of their training. They said that senior staff were available for advise if they require it.
- There were good opportunities for development and training for nursing and allied professional staff. They were encouraged and supported to develop their expertise and competencies and extend their skills. There was a medical library on site and staff were allowed reasonable time to study for relevant courses and projects.
- Revalidation of nursing staff was supported by the trust, resources and training was provided to assist staff with this process.
- Staff were encouraged and supported to develop; several health care assistants had successfully gained places on operating department practitioner courses and were currently studying or waiting to start their training in theatres at the Christie.
- Staff were very positive in the support and investment placed on their learning and development.
- New staff and students stated there was good access to learning and opportunities to further their knowledge and consolidate their training. They stated the mentorship and preceptorship schemes were effective and support was good.

- The directorate was committed to the establishment, training and development of advanced nurse practitioners (ANPs). The role was considered to be a valuable and necessary one and managers were keen to use their skills and expand their use.

Multidisciplinary working

- There was very good multidisciplinary team working, all necessary partners had input into the planning, assessing and delivering of patients' care and treatment.
- The surgical directorate worked well with other specialism and disciplines to ensure the holistic care of patients.
- Care was coordinated and organised well, regular meetings between members of the team were undertaken and each partner was aware of the plan and their roles within that plan.
- Multidisciplinary ward rounds were conducted where progress and ongoing treatments were discussed with contributions from a range of disciplines.
- The surgery directorate had multi-disciplinary cancer teams (MDCT) who worked in collaboration to create a specialised team with different specialities for example the gynaecology, urology, colorectal, plastic surgeons for complex abdominal surgery procedures. This prevented multiple separate isolated surgeries and encouraged a sharing and enhanced expertise for these complex cases.
- The surgery directorate also worked in partnership with external partners such as other NHS centres and hospital and community partners. The Christie surgical staff conducted surgical procedures on other sites when appropriate and had good relationships with other healthcare providers. They did this where this was in the best interests of patients.
- The directorate worked in partnership with other cancer vanguard organisations to determine and shape the future of cancer services locally and nationally.
- The directorate adopted a multidisciplinary approach to living with and beyond cancer, this involved a wide

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range of professionals and partners and took a wider and holistic of patients, their carer's and families such as the emotional, psychological, aesthetical, social, financial, spiritual effects of cancer.

- Pharmacists attended consultant led multi-disciplinary ward rounds.
- Pharmacy had representation on a number of risk and quality committees including patient safety, clinical research and effectiveness, safe medicines practice, medical gases, nutrition steering group, drugs and therapeutics, drugs management, systemic anti-cancer therapy delivery and the cancer centre services board.

Seven-day services

- Consultants were available 24 hours a day, 7 days a week by telephone. A surgical on call consultant undertook ward rounds for all surgical inpatients at weekends.
- Theatres undertook Saturday surgery lists on an ad-hoc basis, however they planned to formalise this into a regular occurrence to meet the requirements of the trust transformation project.
- Access to out of hours urgent scans (i.e. X-ray, ultrasound scans, computerised tomography (CT) and magnetic resonance imagery (MRI) etc.) were available through an on call service.
- Pharmacists were available on a daily basis and operated out of hours cover during evening and weekends.
- Pharmacists provided an out of hours chemotherapy service.
- Occupational and physiotherapists provided a service during core hours at weekends and could assist with patient assessment for discharges.
- Pathology and microbiology services were provided through a partnership with an external provider. A limited service could be provided during the evenings and weekends and during other times urgent tests could be ordered and reported on through an arrangement with a neighbouring hospital.

- Dietitian support was available during weekdays but not on weekends. The medical staff were able to assess and treat patients identified with nutrition or hydration risks during the weekends.

Access to information

- Important information such as safety alerts, minutes of meetings and key messages were displayed on notice boards in staff areas to help keep staff up to date and aware of issues.
- Staff had access to trust and external information including policies and procedures from the trust's intranet. There appeared to be sufficient access to terminal and laptops in the surgical wards and departments.
- The theatre department used an operating theatre information and management system, this advised them on the progress and status of each theatre and procedure, including those cases completed and those waiting to be treated. This was an effective tool which kept the theatres running efficiently and effectively. It also helped them produce accurate statistics and management data to monitor their performance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- An informed consent audit was undertaken in July 2015, which showed that 100% of cases had consent forms completed. However, it also showed that in 55% of surgery cases, the consent was gained by staff with the relevant competency based training qualifications, the remaining 45% were completed by staff who were not trained in obtaining consent. This was an improvement on last year's audit, but worse than 2014 and 2013 audits. A further audit was planned for July 2016. In the meantime actions were in place to increase consent training.
- During our inspection we checked 17 patient records, we found that consent forms were completed in all cases, however we found that four consent forms were illegible.
- Records showed that almost 100% of staff had completed mandatory training on the Mental Capacity Act (2005) and the deprivation of liberty safeguards. The staff we spoke with appeared familiar with the principles

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of the act and the DOLs safeguards, however there appeared to be some lack of awareness of how this was applied to actual patients in their care and who took ownership of the capacity assessment.

- We reviewed the records relating to a patient who we were told lacked capacity. Unfortunately there was no record of a mental capacity assessment being carried out, nor any documentation of the two stage process the mental capacity act legislation states must be completed in order to determine if, how and why the patient lacked capacity. There appeared to be uncertainty over who should undertake this assessment. The patient had been reviewed by the dementia nurse consultant, the surgical consultant and ward staff had had substantial input into care planning, however none of the parties appeared to take responsibility, nor identify that this important process had not been completed.

Are surgery services caring?

Outstanding



We rated surgery services as 'Outstanding' for caring. This was because: -

- We found a strong person centred culture with holistic care provided by highly motivated kind and caring staff who went the extra mile to care for their patients.
- We found that patients were active partners in their care and were engaged in decisions and direction of their care.
- Patients' emotional and social needs were highly valued by staff and this was embedded into their care. There was a wide range of complementary therapies, emotional support, social wellbeing and psychological services available to patients.
- Patients' individual differences were recognised and accommodated without judgement or discrimination. Reasonable adjustments were made and care was tailored for individual needs.
- Feedback from people who used the service was continuously positive regarding the way they were treated by staff. They believed that staff went above and beyond their role in the way they care for their patients.

Compassionate care

- During our inspection we saw that staff within the surgical wards and in theatres were very person-centred in caring for their patients. We saw that staff put patients at the centre of everything they did and strived to make their time in hospital as comfortable as possible.
- We saw staff respond to patients requests promptly and they spoke to them with patience and kindness.
- We observed that staff engaged with patients and talked through and explained everything that was going on and what they were doing, they offered reassurance and support to patients undergoing procedures and interventions.
- Cubicle curtains were drawn and single room doors were closed during consultations and patient care to protect the privacy and dignity of patients and staff sought permission before entering such areas.
- Staff took steps to provide genuine holistic care including their social, mental, emotional and physical needs. They took time to assess patients mental health needs, referring them for counselling to the psychology services if they believed a patient would benefit from this.
- Staff and patients worked collaboratively by discussing ways to improve the ward. They suggested and implemented the provision of a quiet room which was decorated in the colours and furnishings picked out by patients. This room has a calm and relaxed feel and was used by patients or relatives who needed a quiet moment away from the ward environment.
- Staff promoted and facilitated patients' use of the use of the art room, complementary therapies and outdoor garden environment to promote the emotional wellbeing of their patients.
- Staff recognised the benefits of changes to routine and environment, they encouraged patients who were able to use the dining room and social areas to improve their social interaction, stimulate their appetite, encourage mobility and provide a break from the clinical environment.
- Staff recognised and respected the totality of patients and relatives needs and focused on their overall wellbeing rather than their physical ailments. This was

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evident in how the staff carried out their day to day duties and the atmosphere on the wards and in theatres. The staff implemented and demonstrated various initiatives they had introduced to improve the environment, processes and care of patients.

- Staff and patients provided many examples of staff going the extra mile to ensure patients comfort and wellbeing.
- Staff caring for a patient with dementia found out about the patients normal home routine from her carers. They found out her favourite bedtime drink which they gave her each bedtime and they used warming devices for the patients teddy bears, to make the bed more comfortable and familiar to her. They also ensured that each time the patient came to the hospital, she was nursed in the same bed, so as to maintain some consistency in her environment.
- The staff noticed a patient was fed up and down and they gave her a pamper day where staff did her hair styling and make-up application.
- Staff recognised that patients who had been inpatients for a long time often said that what they missed most was a cooked breakfast. Staff arranged for patients who had long stays on the ward to have a cooked breakfast, which was not available through the patient catering providers. The staff made arrangements with another caterer and organised for the breakfasts to be brought to the ward.
- All the patients and relatives we spoke with were very positive about their care and treatment; they felt that staff were exceptionally caring and kind and that they went out of their way to ensure they had everything they needed.
- Patients made comments such as “they are like my family”, “the staff are angels” and “I wouldn’t be here now if it wasn’t for them”.
- The NHS friends and family test (FFT) is a survey, which asks patients whether they would recommend the NHS service they have used to their friends and family. The results for the surgery directorate in from April 2015 to March 2016 were that on average 97% of patients would recommend having their treatment at the Christie. The average response rate for this survey was 73%, which was much higher than the England average of 24.1%.

- The trust undertook their own in-patient survey annually, they were compliant with their targets and the survey was very positive. 100% of patients said they were treated with compassion.
- In the staff friends and family test dated November 2015, 98% of staff recommended the Christie as a place to receive care and treatment, this is much better than the England average of 79%, the survey was completed by 30% of the total staff at the Christie.

Understanding and involvement of patients and those close to them

- Each patient had a photograph of the named nurse looking after them above their bed.
- We spoke with patients about the support of the multi-disciplinary team and allied health professionals such as occupational and physiotherapists. They reported that they had been taught and encouraged to participate in exercises both with the staff and when alone, which made them feel empowered to take control of their recovery.
- Patients who were able were able to self-administer their medication, without feeling dependent on the nurse to administer them. They were supported in this by pharmacists and nurses who offered education and advice on their concerns.
- The patients and relatives we spoke with told us they found all members of staff respectful, responsive and approachable. They reported that staff of all levels listened to what they had to say, acted upon their concerns and addressed any issues. Patients said they felt they had sufficient time to ask their questions and had all their questions answered.
- Patients said they received clear and comprehensive information about their care and treatment in a way they understood. They felt this enabled them to make informed choices about treatment options. This is supported by what we saw during our visit.
- Patient and relatives told us they not only felt included in the decision making process, they were active and equal partners in their care. They said their individual needs were valued and taken into account during the planning and delivery of their care and treatment and treatment plans were not imposed on them but decided upon through discussion and agreement.

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- We saw that staff acted upon the individual preferences that were expressed to them and communicated these sensitively to other departments in the patient's journey. Records were updated to include individual preferences and staff actively solicited the views of the patient and family to proactively tailor the service provided.

Emotional support

- The surgery directorate and the Christie as a hospital offered a host of emotional support to their patients.
- The complementary therapy department offered a range of therapies such as hypnosis, massage and reflexology to assist patients and their emotional needs. Practitioners provided therapies on the wards for surgery patients and in a therapy room at the pre-operative clinic which patients could drop in to on an ad-hoc basis or through pre-arranged appointment. The staff helped patients deal with anxieties and stress regarding pending treatments and helped them relax or deal with fears or phobias of needles, blood or hospitals etc. and could undergo hypnosis and counselling.
- Surgical patients could gain support from the 'look good, feel better' and 'colour me beautiful' therapists who gave advice and support on appearance, clothes and makeup.
- The hospital had an advice centre which provided patients, their children, parents, partners and carers and with an extensive range of leaflets and advice on various aspects of cancer treatment including emotional support.
- The hospital provided a wig fitting service and a free wig voucher for those whose treatment caused hair loss; this could be used at several outlets in the area or at the wig fitting service at the Christie. This supported patients to deal with the emotional effects of cancer treatment as well as dealing with practical support.
- Assessments for anxiety and depression were undertaken at pre-operative clinic and during the patient's stay in hospital, if any needs were identified they were referred to psychology oncology service for an assessment, treatment, therapy, counselling and any reasonable adjustment arrangement that may be of help to the patient.
- Bereavement and counselling services were available to relatives and carers through the bereavement service.
- Staff were provided with access to wellbeing services to help them to continue to deliver effective emotional care to their patients, which the hospital and therapy providers recognised could be a challenge for staff.
- Clinical nurse specialists were available to provide condition specific emotional support for patients with specific needs such as the colorectal and stoma nurse specialists who offered support for those who required a stoma formation or those who already had a stoma.
- The chaplaincy and spiritual service was available for spiritual, religious or pastoral support to those of all faiths and beliefs. There was a multi-faith prayer room in the hospital.

Are surgery services responsive?

Outstanding



We rated the surgery services as 'Outstanding' for being responsive to patient's needs. This was because: -

- There was a holistic and person-centred care approach to the delivery of care for patients across all age groups. We saw positive examples where patient's individual needs were met, such as patient activities that were planned and based on their personal preferences.
- A wide range of complementary therapies, wellbeing and support services were provided to patients and their carers, most of which were free of charge. These services were widely available and accessible to surgical patients pre and post operatively and were very well received and valued by those using the service.
- Surgery directorate at the Christie offered specialised bespoke surgical treatments to patients with unusual, complex and advanced cancers, many of whom had been told no treatment was available.
- The services were planned and delivered to meet the needs of local people and the needs of those from further afield. The facilities and environment were generally suitable for the provision of the services it delivered.
- There was good access and flow with good referral to treatment times, low rates of delayed transfers of care and discharges and low levels of cancelled operations.

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- There were low rates of complaints and those complaints were investigated fully with positive outcomes made from recognition of areas for improvement.

Service planning and delivery to meet the needs of local people

- The surgery directorate provided day complex and specialist curative and palliative cancer surgery covering colorectal, urology, gynaecology and plastic surgery specialisms on site at the Christie. Services were commissioned by national NHS specialised commissioning teams.
- Hospital episode statistics data (July 2014 to June 2015) showed 4,219 patients were admitted for surgery at the hospital of which 63% had day case procedures, 34% had elective surgery and 3% were emergency surgical patients.
- The Christie had two 24 hour, seven days a week inpatient wards, one day surgery ward which was open from 8.00am to 8.00pm Monday to Friday and 5 operating theatres which ran from 8.00am to 8.00pm Monday to Friday.
- The surgery directorate provided care and treatment for a wide geographical area, 69% of patients were from the greater Manchester area, a further 22% were from the wider North West England region and the remaining 9% were from other parts of the United Kingdom.
- The Christie was one of only three specialist cancer centres in England and one of only two that provided peritoneal tumour abdominal surgery. They received referrals for specialist treatments from other NHS Trusts usually concerning cancers that are complex, rare and very advanced.
- The Trust undertook large numbers of clinical trials and conducted a lot of research. 17% of patients were at the time of inspection were participating in a clinical and surgical trials.
- Many surgical patients had their surgeries planned specifically for their unique conditions, with surgery pioneered by the Christie, often using teams working together from different disciplines and surgical specialities.

- The facilities provided for the delivery of surgical services at the Christie were on the whole appropriate for the services that were planned and delivered. However, the facilities at the pre-operative assessment clinic were not ideal, being located away from the hospitals main facilities there was no television, drinks or snack machine. The waiting area was very small and patients speaking at reception could be overheard by those in the seating area. This was a temporary arrangement pending the completion of the new building.
- The areas we inspected were compliant with same-sex accommodation guidelines, we observed that males were cared for in separate areas to females and the trust has reported no breaches to this policy.

Access and flow

- Surgical patients were in the main, admitted by pre-planned appointments for elective procedures. Some surgical patients were admitted via the oncology assessment unit if it was assessed they required surgical treatment.
- Bed occupancy for surgical wards was 82.4%, whereas the England average was 88%. The directorate did not have any issues with delayed transfers of care and they generally always had beds available for urgent admissions.
- Referral to treatment times for surgical patients was consistently within 18 weeks for greater than 90% of patients. For urology patients this performance indicator was met for 92.4% of patients and in plastic surgery this was met for 96.4% of patients.
- The day surgery ward operated a nurse led discharge process. Nurses received additional competency based training to assess patients' fitness for discharge. If they had any reservations they could refer to surgeons for further input.
- Upon discharge patients GPs were sent a summary of the treatment their patient had received, these were computer generated documents, which were both faxed and posted to the GP surgery.

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- Patients were given discharge booklets and information about the procedure they had received. They were also given details of who to contact if they had concerns in the days following their discharge and the Trusts 'hotline'.
- All patients discharge from the surgery areas were referred to the district nurse services. The wards had a robust system for ensuring district nursing services had received and acknowledged their referrals by using follow up to fax phone calls.
- Only five patients operations were cancelled for non-clinical reasons in the six months from October 2015 to March 2016, of those all had their operations rescheduled and completed within 28 days.
- 53 operations were cancelled for clinical reasons in the six months from October 2015 to March 2016, this was mostly where patients were deemed unfit for surgery.
- The care of a patient on a ward that was not best suited to their needs such as surgical services patients who were cared for on medical wards were classed as 'outliers'. There were no surgical outliers on medical wards. Some patients were cared for on the oncology assessment unit overnight when they were first admitted but these were always repatriated to specialist surgical wards the next day. There were sometimes medical outliers on surgical wards and we saw some patients during our inspection. These patients were assessed for their nursing requirements and we saw that their care was within the skill set of surgical nurses.
- There was a multi faith chaplaincy and spiritual care service team who were available on site at the hospital during core hours and available 365 days a year, 24 hours a day, seven days a week through an on call service. The team ensured that all patients and their carers of patients in the last days of life received a spiritual assessment.
- The hospital had a chapel, a Muslim prayer room, and a multi-faith room. Chapel services took place regularly and could be attended by patients, carers and staff. They also had a prayer request book available for anyone to use.
- Each surgical ward had ward champion and link nurses including ones for learning disabilities, dementia, palliative care and stoma care. Every month there was focus on a different aspect of care and during the relevant link nurse presented teaching sessions displayed guidance and facts about their area on the notice board. This was to raise awareness and improve knowledge and competence in dealing with patients' individual needs and others aspects of care.
- Ward 10 was the designated dementia friendly ward. They had undertaken a lot of work to improve awareness of dementia and improve the environment for patients living with dementia. They had painted each bays a different and distinctive colour and had named them that colour (i.e. red bay) in order for patients living with dementia to better find their way back to their bed. They had planned for changed in the signage as it currently did not comply with best practice guidance for dementia care. There were other aspects of the environment which did not met best practice such as the colour of toilet seats and door surrounds which guidance suggests assists patients living with dementia to navigate their surrounding better.
- The receptionist on ward 10 had received specialist dementia training at 'the house of memories centre' in Liverpool.
- The trust and surgical directorate has pledged to follow the Dementia Action Alliance's 'Dementia Friendly Hospital Charter' and produced a comprehensive 'dementia vision' strategy document and action plan to improve services for patients living with dementia over the next 4 years.

Meeting people's individual needs

- Patients with complex, unusual and advanced cancers were offered tailor made, often multi-speciality surgeries based on their individual presentations. The treatments may be curative or palliative but often produced improvements in quality of life and positive outcomes.
- The trust and surgical directorate offered a professional face to face interpretation service for patients whose first language was not English.
- Literature was offered in a wide range of different languages, and if they were not available immediately, could be downloaded and printed at the information centre.

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- Surgical wards identified and encouraged patients who were capable of and who wished to self-medicate during their stay in hospital. Many of these patients were identified and assessed at pre-operative clinic before their admission. This encouraged independence and autonomy for patients, but enabled pharmacy and ward staff advice and support to be given if required.
- The trust had a 'psycho-oncology' department who were available to provide psychiatric assessment and treatment, psychotherapy, cognitive behavioural therapy and counselling to patients with acute or chronic psychological problems. The team comprised of a consultant psychiatrist together with counsellors and therapists. They were also available for guidance and training for staff. During our inspection, we saw evidence of a staff using these services due to concerns over a patients' low mood and for those with known mental health problems and dementia.
- Patients across the surgery directorate services were offered a range of complementary therapies (such as massage, aromatherapy, acupuncture, reflexology, therapeutic touch, hypnotherapy, creative visualisation, phobia therapy, smoking cessation and alcohol management advice). These were available both pre and post operatively for patients. Patients who were nervous or anxious on the days and weeks leading up to their surgery could receive therapy for their worries. These services were delivered free of charge and were also available to patients' carers and relatives.
- Complaints were handled centrally and were referred to managers in the relevant departments to assist with investigations.
- Complaints were responded to within 25 days, only one complaint missed this deadline in the last year, this due to a computer admin error.
- The details of all complaints received were presented to the trust board and management board each month within the performance report. Any similar themes from complaints were highlighted to identify trends or areas of concern. The patient experience committee (PEC) were responsible for circulating learning and any escalation was done through the risk and quality governance group.
- During our visit, we saw evidence that wards acted on complaints and take positive action to implement changes to improve the patients' experience. Learning and investigation of complaints were discussed at team meetings, safety huddles and circulated in newsletters.
- The Christie had a patient advice and liaison service (PALS) which provided a range of advice for patients and relatives.

Are surgery services well-led?

Outstanding



We rated the surgery the Christie as outstanding for being well-led. This was because: -

Learning from complaints and concerns

- Patients knew how to complain and raise concerns, there was information about the 'have your say' campaign on noticeboards and at various points around the hospital site. A 'Complaints, Concerns and Compliments' patient leaflet was available which provided information on how to complain and provide feedback on services received. Details were also available on the trust website, there was a 'webform' that could be completed electronically and submitted to the trust.
- The surgical directorate received 18 complaints in the 12 months between March 2015 and Feb 2016. These included complaints about communication, disagreements with procedures or treatment and delays in care.
- The directorate had a high level of satisfaction across all staff groups. There was a tangible, extremely positive culture amongst staff and they were proud of their organisation and the service they provided.
- The Christie commitment pledges provided consistently high levels of engagement with staff. The leaders inspired staff involvement and collaboration in innovation, improvement and raising standards. Staff were motivated and driven and fully committed to trust and directorate shared goals.
- The organisation took steps to improve the health and wellbeing of their workforce by considering their holistic needs. They offered psychological counselling and

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debriefs, welfare advice including financial and legal consultations, complementary therapies and relaxation therapies and use of the art room to assist with mental wellbeing.

- The surgery directorate and trusts hospital's vision and values were to become the national leading proponent of cancer services and a recognised player on the world stage. This vision and strategy was cascaded and embedded across the surgery directorate. Staff had a clear understanding of what this involved and their role in that strategy.
- The directorate was aware of key risks to service provision, they used quality and performance data and audit findings to monitor and act upon challenges and opportunities through trust and divisional governance and team meetings. They benchmarked themselves against national and international standards and compared favourably to surgical outcomes and standards.
- The leadership sought continuous improvement and innovation in the surgical procedures they delivered. The directorate was always looking for innovative ways to improve treatments for patients and endeavoured to become a world leader in cancer surgery. There was heavy involvement in research and clinical trials programmes in order to improve the care and treatment provided for patients.
- The Christie was a national leader in cancer research including driving forward new surgical techniques and collaboration with other disciplines to develop novel combination treatments and reporting outcomes to share knowledge with others.
- The surgical directorate gather feedback and outcomes from their pioneering surgeries to produce research publications to share outcomes and feedback information to research organisations such as Cancer Research UK.
- The surgical directorate worked in collaboration with other healthcare providers both locally and nationally through the vanguard projects, through provision of cancer services in local NHS trusts and through the sharing of advice and expertise by acting as a centre of excellence and point of contact for cancer treatment and procedures.

- The directorate sought feedback from service users from various equality groups in order to assess performance ensure equality in hard to reach, minority and underrepresented groups.

Vision and strategy for this service

- The trust had a five year strategic plan called 20:20 vision, was based on four principles: 'leading cancer care', 'the Christie experience', 'local and specialist care' and 'best outcomes'.
- The Christie was part of the national cancer vanguard and the Manchester cancer vanguard and saw this as an opportunity to become a world leader in cancer services. They worked in partnership with other organisation to shape the future of cancer treatments locally and nationally.
- They were also involved in the 'healthier together' project and the 'devolution Manchester' strategy.
- The surgery directorate had its own 20:20 vision strategy this included developing new surgical treatments and continuing the advancement of technology in the surgical field.
- The surgical directorate planned to develop surgical services outside of the main Christie site in partnership with others, working collaboratively to improve outcomes for patients.

Governance, risk management and quality measurement

- The whole surgery directorate had a formal meeting every two months. This provided opportunities to discuss performance and audit results and highlight issues and risks. Learning from complaints and incidents was shared; new initiatives and changes were introduced and there were updates on finance, staffing and progress on action plans. Minutes from these meetings were recorded and circulated to all staff.
- There were also monthly ward and department meetings and regular staff ad-hoc meetings and safety huddles to discuss prominent issues and to share information. Theatres had a huddle every morning and the wards had huddles attached to their handovers. Important information was also shared on notice boards and around wards and theatre areas.

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- There was evidence of effective clinical governance procedures and quality measurement processes, these enabled risks to be captured, identified and escalated through different committees and steering groups. This supported the dissemination of shared learning and service improvements and an avenue for escalation to the trust board.
- The directorate maintained and reviewed a risk register. Managers and staff were aware of departmental risks, performance results, serious incidents and other quality measurements. Information relating to key performance indicators such as safety, quality and performance was monitored and cascaded to staff through integrated performance reports. Such information was red, amber, green (RAG) rated to identify areas of good performance and areas for improvement. We saw evidence that this was being acknowledged and responded to in theatres and on surgical wards.
- Individual ward and theatres managers sampled aspects of care delivery each month, such as documentation, medicines management and discharge planning and thoroughly reviewed patient care and records. Any issues were brought to the attention of staff in order to improve quality.

Leadership of service

- The surgery directorate was led by an approachable and visible clinical lead, who was positive and passionate about their directorate. He was supported by clinical speciality leaders in urology, gynaecology, colorectal surgery and plastic surgery.
- The wards and theatres were led by managers who reported to the surgical matron.
- There were clearly defined leadership roles across the surgery directorate. Staff were clear on the management and reporting structures and where they fitted within that chain of command.
- Staff spoke very highly of their local, directorate and trust managers and leaders. They described an accessible, supportive and inclusive management process, in which they felt valued and listened to and were encouraged to reach their potential.
- All leaders appeared to be competent, knowledgeable and experienced to lead their teams and understood the challenges to good quality care and what was

needed to address those challenges. Leaders strived to deliver and motivate staff to succeed and to continue to improve. Managers sought to improve the workforce culture to engage with staff to achieve advances in care and quality.

- Leaders worked closely with other directorates and departments, offering a truly joined up and integrated approach to the treatment of cancer. This achieved advances in the care and treatment, improved the patients journey and experience.

Culture within the service

- We saw that a very positive culture within the surgery department across all wards and departments. Staff were very proud of their hospital and the work they did. They were enthusiastic and passionate about the care they provided and the achievements they have accomplished. There was a tangible sense of willingness to go the extra mile and do the very best for their patients.
- Staff told us that working at the surgical directorate in the Christie was far from a depressing job as people might assume. We were told, “it is a privilege to work here and it is an inspiring and uplifting place to work”. “I feel great job satisfaction and would not like to work anywhere else because care here is second to none, the patients come first and we strive to do the best for them” and “we get great support from managers and each other, it is like a family”.
- Records showed the average sickness rate for staff across the trust was 2.9% at April 2016. The sickness levels were within the hospital’s target of below 3.4% and better than national averages for the period.
- A ‘freedom to speak up guardian’ was in the process of being appointed as per national recommendations, this individual was to encourage staff to raise concerns where they something that concerns them. Staff told us they were supported and free to express their concerns and speak openly about issues that concerned them. Staff felt there was a supportive ‘no blame culture’.
- Staff had received training on the duty of candour, if it had been deemed relevant to their role. However all staff have been given awareness sessions and are

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expected to participate in the process by reporting incidents and being open and candid about incidents and concerns. There is evidence that the processes are robust and effective.

- Staff told us that their managers were supportive of them as individuals, both in terms of their personal and domestic situations and their professional development. They said that managers were flexible and accommodating and were fair and even-handed.

Public engagement

- The trust has various patient groups and patient support groups who are regularly consulted on relevant issues and plans in order to gain feedback. Some of these were surgery related such as stoma groups and pelvic cancer groups.
 - Feedback was sought from various sections of the population and equality groups such as young people, black or minority ethnic and lesbian, gay, bisexual and transgender groups.
 - The Christie charity had a very large following, members of the public and staff regularly participated in fundraising and sponsorship events and initiatives. Staff within the surgical group were Christie charity supporters who were undertaking sponsored walks to raise funds.
 - The trust has an information centre on site, which stocked an impressive range of literature, and leaflets. They also provide videos and audio recordings and other useful sources of help for patients, relatives and carers. The centre provides information and advice on surgical procedures, specific types of cancer and surgical treatment alternatives.
 - Information on how the public could provide feedback was displayed in the surgical wards and corridors through their 'have your say' scheme and information on how to engage with the trust was provided on their website site.
 - The trust engaged with the public through social media sources, which were up to date and current. This system provided information about all services but included information and advice specific to surgery and surgical wards, this was found to be particularly useful in updating patients what to expect regarding their appointments and surgery during episodes of industrial action.
- A wide range of information including policies and procedures, surgical and condition specific information was available via the trust website.
 - As part of the peri-operative audit which ran from January to April 2016, the directorate sought feedback from patients to determine their experience of the surgery process. The outcome was a positive response from patients.
 - The trust has a membership of 30,000 members, who were sent two issues of the membership magazine 'Headlines' each year along with an invitation to the annual members' meeting and any open days held through the year.
 - As part of ensuring a representative membership, the trust has engaged with communities to reach under-represented groups such as black and minority ethnic (BME) and young people. This was supported by the governors' activity and the Christie equality and diversity committee.
 - The surgery directorate hold regular 'open days' which run tours of the operating theatres along with a surgery robot demonstration for members of the public.
 - The hospital's governors sought feedback from patients including surgical patients between August 2014 and July 2015 and found that this was mostly positive; this information was shared with staff and was posted in surgical newsletters.

Staff engagement

- The 'Christie commitment' was an initiative by managers to actively engage with staff and improve their working experience. They made a series of pledges of how they would improve communication, health and wellbeing, recognition, learning and development and pride.
- Events such as 'one week all staff' took place twice a year that gave staff the opportunity to tell managers what it feels like to work at The Christie and what could be improved upon.

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- The trust provided a free staff counselling service for staff. Staff on the surgical wards told us this was well used and staff stated that they found this beneficial to their welfare.
- The trust also provided a practical advice and welfare service for staff in areas such as legal, housing and financial matters. There was also a good uptake on these services from surgical staff.
- Staff could access complementary therapy and use the art room during the staff session on a Thursday afternoon to help enhance their wellbeing. This was available to surgical staff and was supported by surgical managers.
- 'You made a difference awards' were awarded to staff who had achieved positive results or outcomes in their work. A member of the surgery directorate had won the award in April 2016.
- Members of the senior executive team carried out routine scheduled walk rounds to engage with patients and staff across the hospital, including the surgical wards and theatres.
- A staff summer celebration evening, which included the annual staff awards, was planned, staff said this was a good opportunity to celebrate their achievements and previous events had been well attended by surgery staff.
- The chief executive undertook informal chats with staff through drop in sessions in the canteen. These proved popular with the surgical staff we spoke with.
- A trust 'team briefing' was held monthly in the auditorium which staff of any grade and speciality could attend. The surgical wards and theatres allowed staff to take time away from their posts to attend if they wished to.
- A staff engagement feedback event was held in June 2016 to provide staff with feedback on matters such as the staff survey, 'you said we did', staff development and the friends and family test.
- Staff told us they received very good support from their line managers and had regular engagement and communication with them.
- Regular team meetings occurred across the surgery directorate. Monthly team meetings were undertaken and daily multidisciplinary team meetings and safety huddles took place on wards and in theatres.
- The trust and the surgery directorate engaged with staff via team briefs, newsletters and through other information and correspondence that was displayed on notice boards and in staff rooms.
- Staff were able to access information electronically to enable them to keep up to date with policy and practice, latest safety alerts and trust strategy and developments.
- Staff told us they were very engaged with and supported by their local and trust management, they knew what was going on in their directorate and the trust and they felt satisfied with the leadership.
- The NHS staff survey 2015 showed the trust performed better than the national average for 11 indicators. The overall staff engagement score for the trust was 4.03, which was better than the national average score of 4.01 for specialist acute trusts.







Innovation, improvement and sustainability

- The surgery directorate had produced a 5-year strategy, encapsulated in its document Review and 2021 Strategy. The strategy has been aligned to the 'Achieving World-Class Cancer Outcomes: A Strategy for England 2015 – 2020'
- Ward 10 had been assessed as part of the 'Christie Code' accreditation system and achieved the highest 'Gold' standard rating in March 2016. The accreditation scheme adjudged the wards performance against standards such as infection control and environment, medicines management, leadership, privacy and dignity, safeguarding and nutrition and hydration.
- The Christie had been highlighted by the National Institute for Health Research (NIHR), as one of the best hospitals in the country for providing opportunities for patients to take part in clinical research studies. Approximately 17% of patients were taking part in a trial at the time of our visit.
- During a recent Research Assessment Exercise (RAE), an independent review of research activity, the Christie was rated first in the UK for cancer research initiatives.

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- The trust and directorate work with Cancer Research UK and are involved with their 'Beating Cancer Sooner' strategy. The work in collaboration to drive forward new initiatives such as the discovery and development of new therapeutics, new surgeries and radiotherapy treatments and use of precision medicine approaches.
- The Christie were seen as a centre of excellence for cancer treatment and played a fundamental role in training and sharing expertise in cancer treatment and surgeries. They were a point of contact for cancer education and advice other provider locally and nationally.
- The Christie has an academic expansion plan in place in partnership with the University of Manchester to increase the number of surgeons and medical staff being trained in specialist cancer techniques.
- The surgery directorate undertook new, innovative and bespoke surgical interventions for patients with complex and advanced cancers offering patients opportunities for improved quality of life and longer survival prospects.

Critical care

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

Information about the service

The critical care unit opened in December 2006, the unit provides level 2 care for surgical, oncological and haematological patients and level 3 care for inpatients who become acutely unwell. The unit treats only adults. The unit comprises an eight bed inpatient facility and an outreach and critical care follow up service. There is critical care consultant cover twenty four hours a day, seven days a week. Onsite cover is as a minimum from 8am -6pm Monday to Friday and on-call cover out of hours. In addition there is twenty four hours a day, seven days a week onsite middle grade medical cover.

There is a relative's suite on the unit providing overnight facilities.

Between 1 April 2015 and 31 March 2016 the critical care unit admitted 534 patients.

During the course of the inspection we spoke to four relatives, three patients and over 35 staff of all grades, nursing, medical and allied health professionals.

Summary of findings

We have judged that overall, the critical care services provided at The Christie NHS Foundation Trust were good because:

- There were sufficient numbers of suitably skilled nursing and medical staff to care for patients.
- The service took part in the intensive care national audit and research (ICNARC) data so we were able to bench mark its performance and effectiveness alongside other similar specialist trusts. The trust performed well overall.
- Incidents were reported and acted upon and used continuously as a service improvement tool. Safety thermometer data was collected and displayed in public areas for patients and relatives to view. The results were also shared with staff, together with the results from relative's surveys.
- The trust had an outreach team with 12 critical care trained, dedicated members of staff who supported wards in the early detection and treatment of acutely unwell patients. The team had a dedicated follow-up service who saw all medical patients on discharge from critical care, together with surgical patients who had been in critical care for more than four days or more, patients who required respiratory support and those delirious.

Critical care

Are critical care services safe?

Good



We rated safe as good because:

- There were systems in place for reporting and learning from incidents. There were sufficient numbers of suitably skilled nursing and medical staff to care for patients
- The unit had no never events, or serious incidents reported for critical care, between February 2015 and January 2016.
- The trust had an outreach team comprising of 12 members of staff covering 24 hours, seven days a week, all critical care trained to recognise and care for an acutely unwell patient on the wards around the hospital.
- The Outreach team had a dedicated follow-up service who saw all medical patients on discharge from critical care, together with surgical patients who had been in critical care for more than four days or more, patients who required respiratory support and those who were delirious.
- The unit used values based recruitment and had recently had the establishment increased to 36 whole time equivalent (WTE).

However:

- The sluice, domestic room and utility room for the unit all had keypad entry; however we found them to be insecure.

Incidents

- Data from the National learning and reporting system between February 2015 and January 2016 indicated that no never events associated with critical care had been reported. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- We were told by the leads for critical care that incidents were mostly low grade; however there was evidence

that there was a reporting culture and learning from incidents. Local investigations were reported monthly from the unit to trust level in order to share incidents with other units.

- We were told that any incidents reported on the unit would be investigated by a band 6 nurse and the results would be disseminated back to the staff. We also saw a desk top method for staff to report incidents via an electronic system.
- During the month of our visit the critical care manager had highlighted pressure ulcers as an incident and it was highlighted on the 'message centre' of the electronic system. When nursing staff logged onto the system it was immediately highlighting to them and they were then able to read the message regarding the incident. The senior sister could, if required, check that all staff had opened and read the incident message.
- The unit is a member of the Critical Care network, working on an audit based improvement programme, looking at main risks that are then discussed. The data is filtered down to staff and placed on the staff board in the unit's staff room.
- The hospital underwent a recent peer review which identified a key theme being medication errors
- Minuted, fortnightly critical care mortality and morbidity meetings were held at the hospital. The meetings were ran on a tier theme; Tier 1 reviewed themes, Tier 2 looked at more detailed incidents and Tier 3, looked at high level investigations
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. The incident reporting system provided prompts for staff to apply duty of candour.

Safety thermometer

- The Patient safety thermometer reported four pressure ulcers, no falls and no catheter-associated urinary tract infections (CAUTI) during the reporting period between January 2015 and March 2016. There are no discernible trends over time.
- On the unit they had monitored 2323 harm free care days.

Cleanliness, infection control and hygiene

Critical care

- The trust performed better than the England average in eight of the 11 indicators from the Intensive care national audit and research centre (ICNARC) annual quality report for infection control rates. All three indicators which were worse than the England average were relating to mortality. It should be noted that these indicators are not risk-adjusted to take into consideration a specialist cancer centre.
- The unit was compliant with key trust policies and we observed throughout the inspection. All staff appropriately washed their hands, using antiseptic hand gels and wearing personal protective equipment (PPE) when delivering clinical and personal care.
- The hand hygiene audit results for March 2016 showed 100% compliance by staff in critical care.
- We observed visitors appropriately washing their hands and wearing PPE on entering the bed spaces in the controlled infection side rooms.
- The unit did not screen patients for C.diff and Carbapenemase-producing enterobacteriaceae (CPE) infections, however, patients were screened at ward level prior to transfer to critical care and no patients were admitted directly from home to CCU, or from a referring secondary care organisation. Isolation rooms for patients with CPE were used and the rooms would be deep cleaned after discharge.
- An infection prevention and control audit was carried out in critical care and the results published on the 5 April 2016, the audit was comprehensive and showed photographs of areas that needed to be addressed and actions taken.

Environment and equipment

- The critical care unit was fully compliant with the most recently available health building guidance, HBN 04-02 (Health building note relating to critical care buildings).
- All bed spaces were fully equipped with the kit required to care for a critically ill patient.
- The unit had two whole time equivalent (WTE) electro biomedical engineering and maintenance (EBME) staff who serviced the equipment.
- The electro biomedical engineering and maintenance department (EBME) undertook all the servicing and

maintenance of equipment. All equipment in the critical care unit was logged on an electronic system which recorded servicing and flagged up when items and equipment were due for service.

- The unit had flagged on their risk register that some monitors within the unit were nine years old and the unit were now experiencing technical failures, which was impacting on patient monitoring. We spoke to EBME staff and they regularly serviced the monitors, but stated that there was no evidence that the monitors were causing safety issues, however the company who supplied the monitors, loaned the unit a spare monitor. The monitors were on the capital bids replacement register. No staff reported problems with the monitors during our visit.
- We saw that resuscitation equipment was checked daily to ensure that the security tag had not been tampered with and the security number was recorded against a date and signature. Records indicated that the contents of the resuscitation trolley were checked monthly.
- The sluice, domestic room and utility room for the unit were all had keypad entry; however we found them to be insecure. We saw cleaning products on display in the domestic room, which had the potential for easy access by members of the public if left unattended in ICU.

Medicines

- The unit used an electronic prescribing system, which could be accessed at the bedside.
- In the unit medicines were kept in a secure room with swipe card entry carried by critical care nursing staff.
- Controlled drugs (CD'S) were stored in a separate locked cupboard within the secure medicines room, with the keys being held on the person in charge of the shift.
- Potassium syringes were stored separately to other control drugs in a secure cabinet.
- Controlled drugs were subject to daily checks by staff and periodically by the pharmacist. We undertook a dip sample check of the controlled drugs during the inspection and found that they were all in date and the stock numbered tallied with the controlled record book.
- Controlled drugs brought in or belonging to patients were recorded in the back of the CD register.

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- The unit had two secure medicine fridges within the medicines room, staff had had difficulties with the locks on the fridges, as they were small key locks and hard to turn and had reported that they needed replacing.
- The medicine fridges and room temperatures were checked daily and temperatures recorded.
- Patient's allergies and irradiated blood were clearly documented on the unit's electronic patient records system used by the unit. As staff logged on to the patients records, any allergies would be highlighted on the bar at the top of the screen.
- Patients also wore white wrist bands edged in 'red' to indicate that they had an allergy. The type of allergy was written on the wrist band.

Safeguarding

- There were internal systems in place for raising safeguarding concerns. Staff were aware of the process, knew how to escalate a safeguarding incident and who the safeguarding lead was. Recently a safeguarding issue was raised by the unit when a child was found alone in the visitor's waiting room, after their relative had been admitted to critical care. The safe guarding team were alerted quickly and an appropriate referral made by the unit.
- Safeguarding training was part of the trust mandatory training programme. The figures shared with us were measured at business group level.
- 96.6 % of staff in critical care had completed training in safeguarding adult's level 1. 96.6% had completed training in safeguarding children level 1 and 40% in safeguarding children level 2. The trust target for compliance was 95%. The requirement for safeguarding adults level 2 training came out in March 2016 and training was on-going at the time of our visit.

Mandatory training

- Mandatory training was carried out mainly on e-learning and some training was classroom based, for example; moving and handling and 'Prevent' training. The figures for critical care showed the compliance for moving and handling as 84%.
- At the time of our visit the unit reported mandatory training as 86.5% compliance, the trust target for compliance was 95%.

- Resuscitation level 1 training was 100% compliant and transfusion administration (practical assessment) was 97.7% compliant. Dementia training was 98% compliant.

Assessing and responding to patient risk

- The trust had an outreach team comprising of 12 members of staff covering 24 hours, seven days a week, all critical care trained to recognise and care for an acutely unwell patient on the wards around the hospital.
- Modified early warning score (MEWS) system was in place for recognition of deteriorating patients, supported by a seven day outreach team.
- The wider hospital used a patient tracking system; the system allowed automatic alert and escalation of deranged physiological parameters linked to MEWS. This ensured that the most appropriate clinicians were informed when a patient became acutely unwell. The outreach team also alerted critical care of any deteriorating patients on the wards and were able to escalate patients to critical care themselves if they believed it necessary.
- The outreach team attended a hospital handover every morning to discuss patients on wards who were acutely unwell, for example, patients who had high oxygen requirements, or nasal high flow patients.
- The critical care unit held a multidisciplinary team (MDT) meeting every Wednesday which the outreach team attended. On a daily basis they would be informed when a patient was due to discharge from critical care onto a ward.
- The outreach team were contactable from anywhere in the hospital via bleep.
- Any patient receiving standard, or clinical trial based treatment had their psychological state and memory assessed by the outreach team.
- The outreach team's role extended throughout the hospital and this including the close monitoring of patients who were on trial medication, if they were phase 1; first in human trials.
- The Outreach team had a dedicated follow-up service who saw all medical patients on discharge from critical

Critical care

care, together with surgical patients who had been in critical care for more than four days or more, patients who required respiratory support and those patients who were experiencing signs of delirium.

- Patients were seen by the follow-up team within 48 hours of discharge, but the team aimed to see the majority of patients within 24 hours.
- The follow-up team discussed the psychological needs, sleep, mobility and challenges at home with the patient.
- A follow-up clinic was offered to patients discharged from critical care however, we were told that only four patients had attended the clinic in 12 months. This was believed to be due to the amount of appointments that a cancer patient would already be acquired to attend.

Nursing staffing

- We found that the nurse staffing was in line with professional standards of 1:2 nurse patient ratio for level 2 patients and 1:1 nurse ratio when managing level 3 patients.
- The intensive care society patient acuity measure was being used to determine the number of staff required on duty. The number of planned versus actual nursing and support staff per shift was displayed on a television monitor at the entrance to the unit.
- At the time of the inspection there was adequate numbers of suitably skilled and qualified nursing staff on duty to ensure that the patients received safe care and treatment.
- There was a band 7 supernumerary shift co-ordinator.
- The unit used values based recruitment and had recently had the establishment increased to 36 whole time equivalent (WTE) staff.
- The trainee nurses in critical care had a supernumerary period of approximately six weeks, but this would be extended if necessary, according to the individual.
- A health care assistant (HCA) had recently been recruited on the unit to assist with hygiene needs and positive changes.
- The unit did not use agency staff and the bank staff they used were their own critical care staff.

- We observed a morning nursing handover during the inspection. Five band 5 nurses, one band 6 nurse and one HCA was present. The nurse in charge (NIC) led the handover.

Medical staffing

- The unit had a named critical care clinical director and nine whole time equivalent (WTE) critical care consultants. The unit also had eight WTE speciality Doctors and two WTE Deanery Doctors.
- The consultants provided full session day time cover; 8am to 6pm. A handover between consultants took place at 8pm then consultant cover would be on call. Weekends were all so covered by on call. Consultants were available 24/7 and within 30 minutes travel time to the hospital.
- Critical care consultants did not cover theatre out of hours, as this was covered by another hospital in the Manchester Network.
- Two anaesthetists were on call out of hours.
- Clinical consultant ward rounds took place twice a day. At 8am the registrar would handover and at 11am there would be a review of patient's results. A further review would also take place prior to a handover at 6pm.
- The consultants were dedicated to critical care, however when on-call, they covered the whole hospital.
- The critical care consultants covered the theatres and there was a service level agreement (SLG) with a university hospital within the Manchester network that their aesthetic department provided consultant cover out of hours.

Major incident awareness and training

- The major incident policy was easily accessible on the trust internet and staff knew where to find it.
- Staff were aware of where the emergency exits were on the unit and how to evacuate patients in an emergency.
- We were told that in the case of an emergency evacuation, ventilated patients with their own cylinder supply would be evacuated as the critical care unit was situated on the ground floor. There was a business continuity plan in place for this.

Critical care

- Critical care leads told us that they had been involved in advanced planning with the critical care network to respond to a major incident as a result of a terrorist incident.
- Duty managers were 100% compliant for emergency planning training and senior managers were 100% compliant in risk management awareness.

Are critical care services effective?

Good



We rated effective as good because:

- Staff were aware of policies and procedures relating to obtaining consent and the processes related to best interest decision making.
- A physiotherapist saw all patients in critical care who had been ventilated, regardless of the amount of days they had been ventilated for. They were assessed and if appropriate, routinely had 45 mins of physiotherapy as per the National institute of health and care excellence (NICE) 83 guidance.
- The Critical care unit had a designated clinical practice educator in post, responsible for coordinating the education, training and continuing professional development (CPD) framework for critical care nurses.
- The Intensive care national audit and research centre (ICNARC) data showed that the trust performed better than expected in 'Risk-adjusted mortality –predicted risk'.

However:

- The pharmacist covering critical care during our visit was a band 7. The consensus of critical care pharmacists, the UK Royal Clinical Pharmaceutical Society and the Royal Pharmaceutical Society is that there should be at least 0.1 WTE 8a specialist clinical pharmacists for each single level 3 bed and for every 2 level 2 beds. The pharmacist we spoke to had received an induction to critical care and had shadowed a surgical pharmacist on the unit for two to three weeks, until competent.

Evidence-based care and treatment

- The critical care unit demonstrated continuous patient data contributions to the ICNARC. This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally. The leads did tell us that they had spoken with ICNARC and had discussed adjusting comparisons with other hospitals so that the figures were more meaningful, as 'Similar units' were not specialist hospitals like the Christie.
- The critical care units were also subject to annual peer review by the Greater Manchester critical care network (GMCCN) and we saw evidence of a peer review which had just taken place. We saw that all the areas of concern had been reviewed by the unit and action plans developed.
- There were a range of policies and procedures and standard operating protocols in place, which referenced evidence based guidance and these were easily accessible via the trust website.
- Care was provided in line with National Confidential enquiry and patient outcome and death (NCEPOD) and in line with the Royal College of surgeons (RCS) guidelines.
- The unit adhered to local policies and procedures.
- All Patients admitted to the unit were routinely screened for delirium and then every 12 hours during their stay.

Pain relief

- There were processes in place to access patient's pain and the pain scores were recorded on the patients' medical notes and/or on the electronic system and monitored. A recent Critical care patient experience survey asked how well the ICU staff assess and treat pain, 75% answered 'Excellent'
- As part of their individual care plan all patients in critical care were assessed in respect of their pain managements.
- The unit had a pain lead critical care consultant and three pain nurses who were accessible daily, Monday to Friday. They did not attend the ward rounds, or the MDT Wednesday meeting, but did review the patients in critical care and attended when required.

Nutrition and hydration

Critical care

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- The dietician would make daily morning visits to critical care to assess patient's needs.
- A nutritional screening tool was used to assess the needs of the patient.
- We reviewed fluid charts and saw that patient's fluid and nutritional needs were being met.
- The dieticians knew about pre-operative surgical patients in advance, for some patients parenteral feed was prepared for immediately after the operation.
- The dieticians did attend the daily ward rounds in critical care, but not routinely. They did however attend the Wednesday MDT meetings.
- The dieticians had access to the policy on the trust intranet to follow for nutrition and nasogastric tube (NGT) patients.
- Staff were appropriately trained, competent and familiar with the use of critical care equipment.
- 50% of nursing staff on the unit held a post registration award in critical care nursing. This is the minimum level required by the intensive care society.
- The critical care unit had a designated clinical practice educator in post, responsible for coordinating the education, training and continuing professional development (CPD) framework for critical care nurses. The role of the practice educator was split between teaching at the university and being on the unit. They were present in critical care for 40% of the time.
- The practice educator worked with staff through their critical care competencies. After mastering the competencies, staff could take up the opportunity to complete a Masters; however this had to be self-funded.
- Staff were given one day a month for study support.
- In the first year, nurses were assessed on their critical care competencies and some staff were sent for two weeks to another hospital within the Manchester critical care network, to be able to become proficient at the competencies. After the first year is complete, the nurses would remain at the Christie; this meant that that once their competencies were achieved, there were enough level 3 patients on the unit, to ensure that the staff could remain competent at their skills.

Patient outcomes

- We were provided with the latest validated and published ICNARC data for the period July 2015 to September 2015, which benchmarked the unit against comparable units nationally.
- The ICNARC Data showed that the trust performed better than expected in 'Risk-adjusted mortality –predicted risk'.
- ICNARC data for unplanned readmissions within 48 hours to the unit were shown to be better than expected
- The unit had employed two staff solely for the purpose of data collection. This ensured continuous data collection and participation in local and national audit programmes. Data collated was discussed at the Acute and critical care directorate monthly meetings.
- The unit had a number of care bundles in place, which are a set of evidence-based interventions. These were audited monthly and included; Adult respiratory distress syndrome (ARDS), Ventilator acquired pneumonia (VAP), Surface, skin inspection, keep moving, incontinence and nutrition (SSKIN), Central venous catheter (CVC) and Confusion assessment method for ICU (CAM ICU).
- It was the responsibility of the practice educator to ensure that staff were competent. For ventilator competencies, staff at the assisting hospital are responsible for signing off staff when they are competent in this area.
- All staff should receive an annual appraisal. According to the data, at the time of the inspection 100% of critical care nursing staff had received their appraisal. New starters to the unit had an interim appraisal at six months.
- The trust carried out an induction day for all new staff, which critical care staff were encouraged to attend.
- All nursing staff appointed to critical care were allocated a period of six weeks supernumerary to allow time for registered nurses to develop basic skills and competencies to safely care for critically ill patients.

Competent staff

Critical care

- Nursing staff completed a set of core competencies as part of induction to the unit and then they were responsible to demonstrate their competency in practice prior to going forward. We were shown examples of step 1 and step 2 competencies by a nurse on the unit. At completion of the competencies the practice educator would make application for the nurse to access the post registration critical care course.
- Newly appointed medical staff received a three day induction to critical care to familiarise themselves with the unit
- The pharmacist covering critical care during our visit was a band 7. The consensus of critical care pharmacists, the UK Royal Clinical Pharmaceutical Society and the Royal Pharmaceutical Society is that there should be at least 0.1 WTE 8a specialist clinical pharmacists for each single level 3 bed and for every 2 level beds. The pharmacist we spoke to had received an induction to critical care and had shadowed a surgical pharmacist on the unit for two to three weeks, until competent.
- The critical care unit had an intravenous (IV) fluids lead who was also responsible for training; however leads of all units had declined additional training, as they stated that mandatory training was sufficient.
- The unit had three pain nurses and a critical care pain lead consultant. The pain nurses did not attend the ward rounds, but did attend the unit daily and reviewed patients every morning, attending the unit if required
- A dietician was always available for the critical care unit and all the patients who required nasogastric feeding support were seen by a dietician. The dieticians did attend the daily ward rounds, but not routinely. They did however attend the Wednesday MDT meetings.
- The outreach team was available 24/7.
- The outreach follow-up team saw all critical care medical patients when discharged.
- The specialist nurse for teenagers and young adults would also attend the Wednesdays MDT ward round if required.
- There was no dedicated critical care pharmacist, the cover was provided by rotation of the hospital pharmacists, as the dedicated pharmacist was on maternity leave. The pharmacists were not trained in critical care. They covered the unit on rotation every two to three months.
- Pharmacy technicians attended the unit, but they were not dedicated to critical care. They were responsible for top-up, stock control /rotation and additional specialist administrative support.

Multidisciplinary working

- Consultant led rounds took place each day. During our inspection we observed a morning round, which consisted of; a critical care consultant, a pharmacist, specialist registrar and a medical student. The specialist registrar presented the patients to the team, having previously seen and examined the patients. Medication changes were discussed and the general health of the patients.
- Multidisciplinary (MDT) ward rounds took place every Wednesday, consisting of; microbiologist, special fellow, dietician, pharmacist, consultant and a nurse
- All ventilated patients in critical were seen by a physiotherapist, regardless of the amount of days they had been ventilated for. They were assessed and if appropriate, received 45 minutes of physiotherapy as per the National institute of health and care excellence (NICE) 83 guidance.
- **Seven-day services**
- Physiotherapists provided seven days a week service, being available on-call at evenings and weekends.
- The pharmacist covered a five day week, with an on-call pharmacist available out of hours and on bank holidays, who covered the whole hospital. On Saturdays the pharmacy was open 10-1pm and technicians were available at this time.
- The biochemistry services were provided by the Christie Pathology Partnership. There was not a routine 24/7 service as there was insufficient clinical need. There is currently a consultation taking place regarding extended working hours and weekend working. Current times of opening of the biochemistry laboratory were Monday to Friday 08:30am to 5pm and restricted hours evenings and weekends. Out of these hours were via POCT analysers, or referral to a named hospital within the network.

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Access to information

- The unit used a blend of methods for recording patient data. They used electronic records and had electronic prescribing, accessible at the patient's bed side. Allied Health professionals used the clinical web portal (CWP) to record their data. When a patient was discharged to the ward, a print off would be given from the electronic system and a paper summary only, of details from CWP. However we were told that all the wards had access to CWP.
- All visiting medical staff annotate any information regarding their patients directly onto the electronic system.
- Guidelines, policies and procedures were easily assessable to staff on the trust intranet site.
- Certain guidelines were accessible to staff direct from the 'ventilated' home screen, for example, NICE Delirium guidelines and Deprivation of liberty safeguards (DOLS).
- Patients relatives were met by a large television screen before entering the unit which provided information on; daily and planned staffing, visiting times, matrons contact name and contact number, ward sisters name, quiet times, safety thermometer results and samples of patient feedback.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Staff was aware of policies and procedures relating to obtaining consent and the processes related to best interest decision making
- The unit had a policy on sedation holds, however one of the medical notes we reviewed, on the electronic system, did not indicate a sedation hold had been carried out on a level 3 sedated patient.
- Sedation holds were consultant led and formed part of the delirium bundle.
- Staff were competent and aware of the mental capacity act and deprivation of liberty safeguarding protocols. We saw an example of DOLS/MCA and safeguarding in patients notes and the appropriate actions had been taken.

Are critical care services caring?

Good



We found caring to be good because:

- We reviewed the critical care patient experience survey for the period of March 2015 to March 2016. 87% of relatives rated the staff as 'Excellent' when asked at how caring they were towards their relative and 12.5 % rated the care as 'Good' when asked the same question.
- Staff and relatives gave us many examples of staff interacting with patients in a caring manner that went above and beyond their general role.
- The follow-up team contacted every medical patient on discharge, enabling the patient to discuss any physical or emotional problems. The unit are aware that it was not just level 3 patients who suffered from psychological problems on discharge from critical care and offered psychological support to high dependency unit (HDU) level patents as well.

However;

- In accordance with Nice Guidance (C683) patients in critical care were having their physical and psychological needs regularly addressed during their stay in the unit, however the information was not being relayed to the staff on the ward on discharge. The outreach team only followed up medical patients.

Compassionate care

- We saw evidence during our inspection of patients being treated with dignity, kindness, compassion, courtesy, respect, and understanding
- We spoke to four relatives who all told us that they could not have asked for better care for their loved ones.
- Patient diaries were in use, however they were not relative driven as the diary was kept on the electronic patient notes, therefore only the staff could access the diary's and input information.
- We reviewed the critical care patient experience survey for the period of March 2014 to March 2015. 87% of relatives rated the staff as 'Excellent' when asked at how caring they were towards their relative and 12.5 % rated the care as 'Good' when asked the same question.

Critical care

- People's dignity and privacy was maintained during episodes of physical and intimate care. Privacy curtains were drawn around people with appropriate explanations prior to care being delivered.
- Staff and relatives gave us many examples of staff interacting with patients in a caring manner that was above and beyond their general role. Two examples of this were; a man, whose treatment had been withdrawn, requested to see his dog. The staff heated the external corridor to the unit and made the patient comfortable with heated blankets in order for his dog to be brought in to him without fear of infection to other patients.
- On another occasion a nurse bought scarfs in for a patient who had lost her hair, because she had seen them and new they would be to the patients taste.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and those close to them so that where possible, they understood their care and treatment. We spoke to four relatives and three patients who all said that consultants and nurses involved in their care all explained continually what was happening to them.
- The critical care patient experience survey for the period of March 2014 to March 2015 showed that 81.6% of relatives rated the staff as 'Excellent' when asked at about the frequency of communication with critical care nurses. One family commented "The care my husband received in CCU was wonderful- as were the staff communications with myself and family."
- Patient information leaflets were available at the entrance to the unit, which provided information on a variety of subjects including; Complementary therapy services, critical care delirium, same-sex accommodation at the Christie, palliative care, reducing risk of blood clots, the wig fitting service and dietary information and nutritional. Comment cards were also available for relative feedback.
- We observed a relative being invited into the unit for the first time and they were given advice by a member of staff on what to expect.

Emotional support

- The follow-up team contacted every medical patient on discharge, enabling the patient to discuss any physical or emotional problems. The unit were aware that it is not just level 3 patients who suffer from psychological problems on discharge from Critical care and offer psychological support to high dependency unit (HDU) level patents as well.
- In accordance with Nice Guidance (C683) patients in critical care were having their physical and psychological needs regularly addressed during their stay in the unit, however the information was not being relayed to the staff on the ward on discharge. The outreach team only followed up medical patients.

Are critical care services responsive?

Good



We rated responsive as good because:

- The hospital had clear policies and protocols for the management of complaints and concerns.
- The ICNARC data showed that the trust performs significantly better than average for out of hour's discharges and emergency readmissions.
- The unit had limited cancelled elective cases of surgery and we saw data to evidence this; one in 2015 and two in 2016
- There were no incidents recorded of patients having to stay in theatre recovery.
- The unit had overnight accommodation attached to the unit, available for relatives to stay. It was clean and well equipped with en-suite shower facilities.
- The complementary therapy team attended the unit daily, Monday to Friday, and offered therapies to patients and relatives, such as; head and neck massage, aromatherapy and visualisation. relatives.

Service planning and delivery to meet the needs of local people

- In 2015, the critical care unit put together a business plan requesting to open a further two bed spaces on the unit, as they had only been utilising six of the eight beds.

Critical care

There had been an increase in gynaecological cases and colorectal surgery and staff felt that more beds were needed. The unit now accommodates 3 Level three patients or 5 level two patients.

- Long term weaning for patients is covered by another hospital within the Greater Manchester network, as there is a unit specialising in weaning problems and runs a community ventilation service.
- The unit had overnight accommodation attached to the unit, available for relatives to stay. It was clean and well equipped with en-suite shower facilities.

Meeting people's individual needs

- During our visit the youngest patient on the unit was 18 years old and we saw a specialist nurse for teenagers and young adults liaising with him. The nurse acted as a key worker, ensuring that the patient understood decisions that were made, discussed the future and offered emotional support, through psychosocial oncology. This is a specialty in cancer care concerned with understanding and treating the social, psychological, emotional, spiritual, quality-of-life and functional aspects of cancer, from prevention through to bereavement.
- The unit had access to an interpreter service if there were any language difficulties between staff and patients and relatives.
- Trust wide there were services available to support blind or hard of hearing patients, however staff we spoke to on the unit were unsure of the procedure to follow.
- A pamphlet with information about critical care was given to patients and relatives on discharge which had been adapted from 'Intensive care unit steps'.
- The staff told us that they were aware of the needs of a dementia patient and were in the process of purchasing a clock which displayed the day, date, month and year in addition to the time.
- If the unit requires a specialist weaning unit they have a working agreement with a local hospital within the Greater Manchester network. This particular hospital is a central specialist weaning unit and is currently setting up a new unit for the networks use.

- The complementary therapy team attended the unit daily, Monday to Friday, and offered therapies to patients and relatives, such as; head and neck massage, aromatherapy and visualisation.

Access and flow

- Monthly key performance data showed that bed occupancy in critical care for the period April 2013 to October 2015 was above 90%, which was higher than the England average.
- Patients were not delayed on the unit when ready for discharge to ward settings. Recent ICNARC data showed that the unit scored better than the England average and this reflected what we saw.
- The trust did not ventilate patients outside the critical care unit.
- Bed capacity in the unit was for three Level 3 beds, or five level 2 beds, if the unit was working at full capacity, systems were in place for a patient to be transferred to another critical care unit within the Manchester network.
- Patients were reviewed in person by a consultant in intensive care medicine within 12 hours of admission to the unit.
- The unit has limited cancelled elective cases of surgery and we saw data to evidence this; one in 2015 and two in 2016
- There was no incidents recorded of patients having to stay in theatre recovery, we were informed that there is an escalation protocol if this was to happen. The outreach team would attend in theatre recovery to care for the patient. If the patient was a level 3 patient, the critical care manager would transfer the patient to the unit and a level 2 patient would be transferred to recovery.
- ICNARC data for the period of 01 April 2014 to 31 March 2015 was positive, showing that the percentage of non-clinical transfers out of the unit fell well below that of similar units.
- Discharge from Critical Care should occur between 07:00hrs and 21:59hrs, this was generally achieved by the unit. On occasions that patients were discharged out of these hours, an investigation was carried out by the Unit.

Critical care

- ICNARC data showed out of hours discharges are better than the England average
- ICNARC data showed that delayed discharges were also better than the England average
- The ICNARC data showed that the trust performed significantly better than average for out of hour's discharges and emergency readmissions.

Learning from complaints and concerns

- The hospital had clear policies and protocols for the management of complaints and concerns.
- A general team meeting was held on alternant months to discuss any complaints raised and learn from the outcomes
- A separate band 6 meeting was held monthly to also discuss complaints and concerns and a communication letter was distributed to band 6 nurses for further awareness and learning.
- Results from the safety thermometer data and relatives surveys were displayed on a public display board on the entrance to the unit.
- The outreach team shared information from their safety patient information sheets, with the Royal Marsden College of nursing, for continuous improvement.
- A band 7 nurse from critical care attended the fortnightly governance meetings where incidents and the risk register were discussed and learning taken to disseminate to staff.

Are critical care services well-led?

Good



We rated responsive as good because:

- There was a comprehensive selection of clinical governance meetings both within the trust and at Network level.
- There was an effective governance structure in place, which ensured that all risks to the unit were discussed within the trust and through regional networks.

- A band 6 communication letter was used to disseminate information, views and ideas, amongst other data to the band 6 nurses.
- Nurses we spoke to said that they were very supported by managers and the practice educator. They also felt they could approach their line managers to report any issues or complaints.

Vision and strategy for this service

- We spoke to the leads whose vision for the unit was to become more self-sufficient, regarding the use of on-call consultants, as they currently used a hospital within the Manchester network for anaesthetist cover. Their vision is to reduce dependency on other hospitals in the Network.
- There was a comprehensive selection of clinical governance meetings both within the trust and at network level.
- Clinical leads told us that they wanted to offer more support to their critical care nurses and to expand their role, so that they were not dealing with patients psychological needs alone. To retain the nurses in the unit, their vision is to encourage them to be involved in clinical trials. The critical care lead had recently enrolled the unit into a forthcoming multi-national trial in, 'Elective major intra-abdominal surgery' which will involve nurses either treating critical care patients with standard care, or four hours of (CPAP) within four hours of surgery. It will be the first interventional trial the unit has taken part in and a meeting was held to inform the band 6 nurses. This has boosted morale within the unit and the nurses feel valued and excited about being involved.

Governance, risk management and quality measurement

- There was a comprehensive selection of clinical governance meetings both within the trust and at Network level. There was an effective governance structure in place, which ensured that all risks to the unit were discussed within the trust and through regional networks.
- There were monthly critical care governance meetings; monthly directorate meetings ward staff meetings and consultants meetings across the critical care services. There was a set agenda for these meetings with

Critical care

standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.

- The critical care leads were aware of the importance of ICNARC data and where they were in the Network and told us they had put a lot of effort into improving their performance from the data.
- The unit was subject to annual peer review benchmark by the Greater Manchester critical care network against the present evidence base and agreed standards for critical care provision. The most recent review by the network had been in May 2016. The peer review in 2015 had identified some concerns, for which the critical care unit had developed action plans for. One of the areas for development identified in the previous review was that the number of Intensive Care registered nurses was below the standard required. This was actioned and the issue resolved.
- There was a risk register for the unit, which was up to date and included controls and measures to mitigate risks. The risk register was updated regularly and risks reviewed and acted upon.

Leadership of service

- The critical care unit had a designated clinical director of critical care, a designated consultant and a team of experienced senior nurses.
- The unit had an identified lead nurse who was a band 8a Matron.
- Staff said they felt supported by senior leaders on the unit.
- Nurses we spoke to said that they were very supported by managers and the practice educator. They also felt they could approach their line managers to report any issues or complaints.

Culture within the service

- All staff we spoke to told us that they felt respected and valued and many made comment that it was the best unit they had worked in.

- We found that the culture encouraged duty of candour and the majority of the staff we spoke to were happy to raise concerns. They described the senior nursing and medical staff as approachable, visible, provided them with good support and made them feel valued.
- There was evidence of collaborative working and positive relationships with other departments within the hospital.
- The practice educator supported each nurse through their role specific training and actively encouraged them to progress with further education.

Public and staff engagement

- The relatives we spoke to said that they felt very included and involved with the care of their loved ones.
- The Critical care patient experience survey was a network designed survey which was conducted between March 2015 and March 2015, from the results a clinical audit action plan was produced with recommendations on areas such as; better signage for the unit and reduction of agency staff.
- The unit had a closed page on social media in order to communicate with the nurses. Training videos were placed on the page, any bank work that was available and praise for staff hard work when appropriate.
- The unit held a number of meetings where they were able to share their views. A general team meeting was held for band 6 nurses and lower on alternate months and a separate band 6 meeting were held monthly.
- A band 6 communication letter was used to disseminate information, views and ideas, amongst other data to the band 6 nurses.
- Staff felt appreciated and areas of excellence were highlighted for teams at the annual staff awards. In addition to this, monthly praise was given to staff with 'You've made a difference' awards.
- Any patient letters or cards of 'thanks' the unit received, were shared with staff on a closed, social media page.

Innovation, improvement and sustainability







- The critical care managers were looking at introducing posters to display monthly incidents on the unit, for the

Critical care

attention of nursing staff. They believed that this approach would ensure that all staff were made aware of the incidents and visual displays would be more effective.

- The council of governor's quality committee conducted a governor initiative and collected patient experience between August 2014 and July 2015, actions were then taken from the results for problematic areas and improvements made.

End of life care

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

Information about the service

We visited The Christie Main Site as part of our announced inspection on 10, 11, 12 and 13 May 2016. Patients with end of life (EOL) care needs were cared for on the general wards within the hospital.

The palliative care team merged with the pain team about twelve months ago with the aim to provide a more integrated approach to patient care as a specialist supportive care team. The Christie Specialist Palliative Care and Symptom Control Team (SCT) is based at The Christie Main Site. The team, which had doubled in size in the last four years, consists of consultants, GP advisors, a clinical nurse consultant, clinical nurse specialists and staff facilitating the care of patients in the final phase of life. They collaborate with the chaplaincy service, social workers, consultants, ward staff, the community link team and pharmacists. The team work closely with patients and their relatives, the hospital doctors, ward nurses and other professionals in supporting the patient's needs. They also liaise with hospices and other community support agencies.

The SCT accepted referrals for patients with progressive life threatening illness when life expectancy is likely to be less than one year. Referral criteria includes difficult pain and symptom control, psychological support and specialist needs related to EOL care and support. The SCT provides specialist advice, education and support as requested for patients on the general wards. Individual wards have EOL

link nurses who had chosen to take on additional training for this role to provide support and guidance to other members of the ward team. The team used the five priorities of care.

Between April 2015 and March 2016 there were 238 deaths at The Christie Main Site. Between April 2015 and March 2016 there were 1082 new inpatient referrals, 749 inpatient re-referrals, 225 outpatient referrals and 294 re-referrals to the SCT. At the trust the service count each time a patient is re-referred so one patient may have been re-referred several times.

During the inspection we visited six wards and an outpatients clinic. We observed a nursing handover. We visited the mortuary and viewing room, the chaplaincy, the complementary therapies room, the medical devices room and the bereavement suite. The mortuary services at The Christie were provided by a different health service provider.. We reviewed the working relationship between the two organisations.

We observed care and looked at records for 20 patients and 10 prescription charts. We spoke with two patients, five relatives and 40 staff across all disciplines including doctors, nurses and health care professionals. We spoke with members of the management team, porters, the chaplain and the bereavement suite manager.

End of life care

Summary of findings

Overall we rated EOL care at the Christie as outstanding because:

- Incident reporting systems were in place and learning from incidents was discussed. There had been no recent serious incidents related to end of life care.
- There was an audit plan in place and actions from audits were contained within action plans and being addressed.
- The service held a weekly multi-disciplinary team (MDT) meeting where cases and new referrals were discussed. Representation from a wide number of different disciplines attended and we saw evidence of good collaborative working across the different agencies and teams.
- We saw evidence that people's individual needs were being considered at end of life and that discussions with patients and their families were taking place. Referrals to the SCT were priority rated and ward staff told us the SCT responded quickly to requests for their input.
- The service was deemed compliant with NICE guidance by NICE.
- The SCT used an innovative approach to their structure, which was recognised by NHS England and is now being rolled out across cancer centres throughout the country.
- The service achieved six out of eight performance indicators in the NCDAM 2016. An action plan was in place to address the other two indicators.
- Staff provided sensitive, caring and individualised personal care to patients who were at the end of their life.
- Awareness of the specialist team was embedded in all clinical areas of the hospital. They were professional, responsive and supportive of patients, relatives and staff.

- The service was carrying out trials and initiatives to improve EOL care for patients within the trust but also across other organisations.

End of life care

Are end of life care services safe?

Good



Overall, in terms of being safe, we rated the Christie end of life service as good because:

- There was an open and transparent culture in regards to reporting incidents and learning was shared across the SCT and the trust.
- Policies and procedures were in place for the safe administration of controlled drugs and anticipatory medication.
- Staffing levels in the specialist team were sufficient for staff to perform their roles.
- Staff were aware of their responsibilities in relation to infection control procedures.
- Syringe drivers were appropriately maintained and there were sufficient quantities so staff could address patients' needs.
- Anticipatory medications had clear guidance in place to assist prescription.
- Records were kept securely.

However,

- Level three safeguarding training was not in accordance with the intercollegiate guidance requirement. The trust had taken action to start to address this.
- AaND (Allow a Natural Death) forms were not consistently completed. However, where information was missing from the form it was contained within the patients' medical records.

Incidents

- There were systems and processes in place to report incidents and staff told us they were encouraged to do so.
- Incidents were graded by the harm resulting from the incident. Incidents were reviewed by a senior staff member. We saw evidence of actions that had been put into place as a result of incidents.

- Staff attended other services morbidity and mortality meetings to ensure that learning was shared across other services.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Duty of candour was understood by staff we spoke with.

Medicines

- The service had achieved its National Care of the Dying Audit of Hospitals (NCDHA) organisational key performance indicator for clinical protocols for the prescription of medications for the five key symptoms at EOL.
- We reviewed 10 prescription charts and found that medication had been prescribed and administered appropriately, including EOL anticipatory medication.
- There were separate sections of the inpatient chart for controlled drugs (CDs), including opiates. There was also a separate CD prescription for outpatients and those who were going to be discharged. There was a patient information leaflet given to those patients prescribed strong opiates. This is in line with NICE Clinical Guideline 140, relating to the safe and effective prescription of strong opiates.
- There was an up to date schedule for servicing and calibrating the equipment, which we saw.
- Staff told us that from time to time they discharge patients with syringe drivers. The equipment was returned to them from the community in prepaid packaging. There was a guide for medical staff to follow on the prescription of anticipatory medication. These were prescribed for patients, including those discharged to their own home or a hospice, to manage pain and common symptoms, if required.
- Some of the nurses within the specialist team were nurse prescribers and supported junior medical staff in prescribing medicines at the end of life. This meant patients could access some medications without needing to wait for their doctor to prescribe it.

End of life care

- We found that overall medicines, including controlled drugs and intravenous (IV) fluids were stored safely and in line with agreed protocols.
- We observed records that confirmed that staff carried out daily checks on controlled drugs and stocks to ensure medicines were reconciled correctly. During the inspection we also checked a random selection of controlled drugs on each ward and department and found the stock balances correlated with the registers. We also saw that the controlled drugs book showed evidence that two staff members had signed for controlled drugs.
- Guidelines for care in the last days of life and algorithms for medications were available on the intranet and hard copies were available on the wards.

Records

- The service was in the process of transferring over onto electronic records. At the time of our inspection nursing records were electronic and medical records, including prescription charts, were paper based.
- We reviewed 20 care records and found good evidence of nursing care documentation, nutrition and hydration reviews and documentation standards. In three of the records there was no evidence that ceilings of care were documented.
- Service leads told us that at the time of our inspection unified do not attempt resuscitation forms (uDNACPR) were being rolled out across the Greater Manchester area. At the time of our inspection the trust used Allow a Natural Death (AaND) forms for patients at EOL. These forms only applied within the trust. They contained patients' information, a do not attempt resuscitation decision, ceilings of care, agreement from the patient (if they had capacity) and clinical reasons why CPR would be inappropriate. We found variable consistency in the completion of these forms.
- Of the records we reviewed, 3/8 AaND forms were not fully completed. However, the missing information was contained within medical records. There was not a risk that patients would be resuscitated inappropriately.
- uDNACPR were completed when patients were being discharged from hospital to their preferred place of

death. The trust had taken the decision not to roll out uDNACPR forms across the hospital as there was debate within the Resus Council regarding the name of the form being imminently changed.

- Most records we reviewed showed some evidence of advanced care planning. Advanced care planning was recorded in different parts of the electronic patient records system. This reflected the practitioner's speciality who had had those discussions e.g. nurses in nursing records, outpatients' staff in outpatients etc.

Cleanliness and infection control

- The service had a care after death policy which outlined infection control procedures relating to care of the patient.
- We observed ward and departmental staff caring for patients at the end of life complying with the trust policies and guidance on the use of personal protective equipment. Staff were bare below the elbow, sanitised their hands between patient contacts and wore aprons and gloves when they delivered personal care to patients.
- We saw on all wards visited that there were hand gels available at entrances and notices reminding staff and visitors to use them.
- The porters we spoke with were aware of the appropriate infection prevention measures to take in relation to deceased patients. The trust confirmed that all porters had undertaken infection prevention and control training.

Equipment

- The trust used T34 syringe drivers for delivering measured doses of pain medication. These conformed to national safety guidelines on the use of continuous subcutaneous infusions of analgesia. The syringe drivers had in-date annual maintenance checks.
- Ward staff obtained syringe drivers from the equipment store. We were told there were no problems accessing syringe drivers whenever they were needed for patients. If patients were discharged home with syringe drivers, they were given prepaid envelopes to return these after community resources had been sourced.

Safeguarding

End of life care

- All the staff we spoke with were aware of their responsibilities regarding safeguarding of patients and the correct procedures to follow; they could describe how to access the policy on the trust intranet and who to speak to for advice.
- 96% of the SCT staff had received their level one Safeguarding training.
- The trust had previously been unclear of requirements regarding the required level of safeguarding training staff should have undertaken. This meant that the trust were unaware that staff should have level three safeguarding training in accordance with the intercollegiate guidance. The trust became aware that their teams needed level three training and at the time of our inspection 47% of the SCT had completed level three training. Plans were in place at the time of our inspection to ensure all relevant staff had level three training within six months.
- The SCT had group and individual supervision.

Mandatory training

- Mandatory training was kept updated by attendance on training courses or by training done remotely on a computer. The subjects classed as mandatory are those which are considered the most important such as basic life support, safeguarding patients and moving and handling.
- The SCT were 91% compliant with their mandatory training.
- All porters received specific mortuary training from the mortuary manager.
- All chaplaincy staff and volunteers were DBS checked and had mandatory training from the trust.
- Each year all trust staff received a presentation on EOL care as part of their mandatory training.

Assessing and responding to patient risk

- Clinical needs of patients were monitored through regular nursing, medical, therapy and pastoral care reviews.
- Staff used tools to assess risks to patients, for example pressure damage and nutritional risks. Tools were

available and used by staff, for example, skin integrity assessments to identify and prevent pressure ulcers. Appropriate pressure relieving mattresses and regular repositioning were given to patients at risk.

- Falls risk assessments were undertaken in patients with impaired mobility.
- Mouth care was provided using sponges or gauze.
- EOLC support was available from the SCT.

Nursing staffing

- The SCT had a Macmillan Nurse Consultant, a Macmillan Clinical Nurse Specialist, 4.07 WTE band seven Clinical Nurse Specialists, a Macmillan breast palliative care project lead, 1.72 WTE nurse specialists and a band five staff nurse.
- There were four nurse prescribers within the SCT and one nurse prescriber in the pain team. Another nurse was part way through their prescribers course and two more nurses due to begin their courses at the time of our inspection.
- Each ward had an EOL link nurse who worked closely with the SCT. The link nurse received bi-monthly training from the SCT. Link nurses disseminated information to the wards via team meetings.

Medical staffing

- The SCT had 1.5WTE medical staff who would see patients and provide telephone advice. The team also had 0.5 WTE GP advisors.
- Medical staff outside the SCT told us they felt well supported by the SCT regarding symptom control and pain.

Major incident awareness and training

- The SCT had plans in place should the computer system fail.

Are end of life care services effective?

Outstanding



We rated EOL care as good in terms of being effective. This was because;

End of life care

- The service was compliant with NICE guidance. The compliance documentation shows 69/71 recommendations were fully met. The remaining two recommendations related to advanced care planning and evidence of this within records. We discussed this with the trust at the time of our inspection. We saw evidence of the introduction of 'goals of care', a tool that should help to address the areas for development.
- 99% of patients were seen by the SCT within 24 hours of referral.
- The SCT used an innovative approach to their structure, which was recognised by NHS England and is now being rolled out across cancer centres throughout the country.
- The nursing lead had recently been to America to review best practice in EOL service provision. As a result of her visit changes were being implemented at the time of our inspection to improve advanced care planning.
- The service scored above national average in the 2016 NCDAAH for the five clinical indicators.
- In the 2016 NCDAAH, six out of the eight organisational KPIs were achieved and were above or in line with the England average.
- We saw the hospital had a regular audit programme and improvements had been made across the service as a result of the findings from these.
- Pain relief, nutrition and hydration were considered in nearly all cases and patients were happy in regards to these outcomes.

Evidence-based care and treatment

- NICE deemed that the service were compliant with its guidance at the beginning of April 2016. The compliance documentation shows 69/71 recommendations were fully met. The remaining two recommendations related to advanced care planning and evidence of this within records. We discussed this with the trust at the time of our inspection. We saw evidence of the introduction of 'goals of care', a tool that should help to address the areas for development.
- The service were also working with IT to improve the electronic record system so advanced care planning was more visible. Training was being provided to staff regarding advanced care planning. The Macmillan breast project nurse was working closely with consultants to increase earlier advanced care planning in patients with advancing disease.
- The Christie had responded to the withdrawal of the Liverpool Care Pathway (LCP), implementation of One Chance to Get it Right and the 5 Care Priorities. The trust had a clear 'care for patient in the last days and hours of life' guidance document. We reviewed audit findings, meeting minutes and saw associated action plans, which evidenced its implementation.
- The SCT had developed a prompt card highlighting to nursing and medical staff within the wards the key priorities for care in the last days of life. We saw evidence of this on the wards we visited.
- The service had a comprehensive local audit programme. Action plans following audits were completed. Learning was shared via MDT meetings within SCT and across the trust.
- Following the NCDAAH the service put in place an action plan. This identified eight areas for improvement including seven day working for the SCT and that education and training in care of the dying should be mandatory for all staff caring for dying patients. At the time of our inspection, we found evidence that all the actions had been addressed.
- The team undertook an audit in January 2016 with the same questions that are contained in the NCDAAH. This showed improvement across all questions. The 2016 NCDAAH also confirmed an improving picture where the service had achieved above national average scores in the five key priorities of care.
- 99% of patients were seen by the SCT within 24 hours of referral.
- The SCT accepted referrals from a range of sources including the wards, outpatients, radiotherapy and chemotherapy and the clinical trials unit. Referrals were also accepted from GPs, district nursing and community based staff. The SCT accepted referrals via a variety of methods including in person (during their ward/outpatient rounds), by telephone or via email.
- Some of the staff we spoke to felt some patients did not have A&ND forms in place early enough. This was said to be due to the 'curative' culture within the organisation.

End of life care

Pain relief

- The SCT at the Christie were an enhanced supportive care team that included the pain management team. Their approach to EOL care was recognised as an innovative approach to patient care. In February 2016 the team had won a quality in care award for the model. The model started to be rolled out across the country by NHS England in April 2016.
- The palliative care and pain teams worked closely together having weekly MDT meetings, which facilitated discussion regarding the best pain management options for patients.
- The SCT triaged all referrals to decide which staff member was best seeing a patient to address their needs. This also meant that if a patient had palliative and pain management needs, a joint appointment could be held.
- The service complied with the Faculty of pain medicines' core standards for pain management (2015).
- The service collated information about the outcomes of people's care and treatment and routinely monitored it. The service reviewed information detailed in the End of Life Care Quality Assessment Tool and put action plans in place to develop the service.
- The latest trust EOL care audit (January 2016) showed in 96% of cases it was documented within the last episode of care that the patient would probably die in the coming hours or days.
- Following the NCDHAH 2014, the service put in place an action plan. This identified eight areas for improvement including seven day working for the SCT and that education and training in care of the dying should be mandatory for all staff caring for dying patients. At the time of our inspection, we found evidence that all the actions had been addressed.
- The team undertook an audit in January 2016 with the same questions that are contained in the NCDHAH. This showed improvement across all questions, which was further evidenced in the 2016 NCDHAH.

Nutrition and hydration

- The SCT had delivered training on nutrition and hydration at EOL. They had developed a series of prompts for all staff, which we observed on wards, to help ensure that patients' nutrition and hydration needs were being addressed.
- Nursing records included a nurses' proforma, which contained discussions regarding food and fluids.
- Each ward had a nutrition nurse for advice regarding nutrition and hydration.
- The service had participated in a national feasibility study for nutrition and hydration in the last days of life. The school of oncology had worked closely with the SCT looking at sub-cutaneous hydration as an alternative form of hydration for EOL patients. At the time of our inspection the team were planning to look at competencies for this before the programme could be rolled out.
- In 87% of cases there was documented evidence of medical reviews.
- In 100% of cases there was documented evidence of a senior medical review and evidence of a nursing review every four hours.
- In 96% of cases there was documented evidence that the patient had had advance care planning or a goal of care discussion.
- In 100% of cases, there was documented evidence of care and support of the patient's family and those important to them during the dying phase.
- In 96% cases there was documented evidence that an assessment and discussion regarding the patient's need for nutrition needs (artificial) and hydration needs was made at any time between the time of the final admission and death.
- In 70% of cases the patient was reviewed by the SCT during their admission.
- In 61% of cases, the SCT reviewed the patient during the last 24 hours of their lives.

Patient outcomes

- The SCT were highly commended in 'The Christie Team of the Year 2015 - best outcomes category'.

End of life care

- In 96% of cases, there was documented evidence of care of the patient immediately prior to or at the time of their death.
- In 82% of cases, there was documented evidence of care and support of the patient's family and those close to them at the time of the patient's death.
- In 83% cases there was documented evidence that the family and those people that are important to the deceased were given any appropriate verbal information following the death of the patient.

Competent staff

- Staff received training from the SCT based on the five priorities of care and services that were available within the last six months.
- The service had recently introduced EOL ward champions for each ward and department. The aim was for there to be two EOL champions for each ward and that they would become the first point of contact for information and to disseminate information. Each EOL champion received training from the SCT every two months.
- All staff at the trust completed the 'breaking bad news' course. They were also invited to attend lectures from the SCT and pain management teams.
- All new nursing and allied health professionals receive half day training on EOL care as part of their induction.
- The SCT taught on the palliative and oncological emergencies study day, which ran alternate months for new clinical starters to the Trust.
- Whilst all medical staff told us they had not received EOL training at induction, medical staff told us that they had accessed discussions with the SCT as part of their mandatory training and knew when to involve the SCT.
- The SCT provided training on end of life care for Junior doctor four times per year.
- Each year all trust staff received a short talk on EOL care as part of their mandatory training.
- The team offered half-day drop in training sessions that all staff within the trust could access.
- The SCT had introduced a new e-learning programme for all staff who were involved with care of the dying.

Staff had to complete this once every three years. At the time of our inspection this programme was being introduced in waves, the first of which started on 7 October 2015. In March 2016 the trust were 70% compliant.

- The SCT had an annual away day which supported learning and development.
- Each ward within the trust had a device worker who kept records of staff competencies.
- The bereavement team provided care after death training to a range of staff which was found to be supportive.
- The Maguire Communications Skills Training Unit provided communication skills training including enhanced and advanced communication skills, train the trainer and communication around uDNACPR.
- The SCT appraisal rate was 100% at the time of our inspection.

Multidisciplinary working

- The SCT worked closely with outpatients, radiotherapy, chemotherapy, and the clinical trials unit. The team also worked with GPs, district nursing and community based staff.
- Members of the specialist team participated in multidisciplinary team (MDT) meetings and worked with other specialists to provide good quality EoLC across clinical specialities. A weekly specialist MDT meeting was held at the hospital. Members of the MDT included consultants, doctors, clinical nurse specialists, discharge co-ordinator, physiotherapists, occupational therapists and a chaplain.
- Ward staff told us they received monthly updates regarding EOL care. If something was urgent this was shared in team meetings/briefings.
- The Chaplain attended the SCT meetings so EOL patients could be identified to the chaplaincy service.
- Ward staff could make an urgent referral to the Chaplain by paging him. For non-urgent referrals, staff could ring the office.

End of life care

- Discussions at the MDT included all patients identified as requiring palliative care and patients who had died or been discharged from the service. They also discussed patients of particular concern where individual team members sought advice or support from the team.
- The MDT worked well together to ensure patients' care and treatment was planned and co-ordinated. There was evidence that emotional support and anticipatory prescribing to support patients at the end of life worked effectively.
- We saw the weekly specialist team handover, where all patients on the caseload were reviewed. The handover was a well-managed session with clear priorities and work plans agreed.
- The trust had introduced Schwartz rounds to share working practices and increase support amongst staff of different disciplines. Schwartz Rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. Staff that we spoke to had actively engaged in these sessions and found them useful in promoting empathy and effective working. The sessions were well-advertised and the trust encouraged staff from all backgrounds to attend.
- Porters worked closely with mortuary staff.
- There was a clear process managed by the community link team for transferring care from the hospital to the community. This was also available on the intranet to support the SCT when they did weekend discharges.

Seven-day services

- The SCT offer a seven-day face-to-face service to the trust's patients. From Monday to Friday the full team were available from 9am – 5pm. At weekends from 9am - 5 pm a nurse was on duty visiting patients and a senior nurse or nurse consultant was on call. Out of hours St Anne's hospice provided a 24 hour helpline.
- The chaplaincy service was available seven days per week. From 9-5 five days a week there was cover on site. Out of those hours an on call service was available for all faiths.

- From Monday-Friday the community link team facilitated rapid discharges. As weekends this was organised by the SCT nurses.

Access to information

- All staff within the SCT had access to a list of patients who were within the last year of their lives. The list was colour coded to ensure all staff were aware of a patient's current condition.
- Staff had access to referral guidelines for the chaplaincy service on the intranet and in the SCT's folder.
- Records for the chaplaincy service were securely stored.
- GPs within Greater Manchester could access their patients' information electronically. Other GPs had to access the Christie Portal to view their patient's information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Service leads told us that at the time of our inspection unified do not attempt resuscitation forms (uDNACPR) were being rolled out across the Greater Manchester area. At the time of our inspection, the trust used Allow a Natural Death (AaND) forms for patients at EOL. These forms only applied within the trust. They contained patients' information, a do not attempt resuscitation decision, ceilings of care, agreement from the patient (if they had capacity) and clinical reasons why CPR would be inappropriate.
- Of the records we reviewed, 3/8 AaND forms were not fully completed. However, the missing information was contained within medical records.
- uDNACPR were completed when patients were being discharged from hospital to their preferred place of death. The trust had taken the decision not to roll out uDNACPR forms across the hospital, as there was debate within the Resus Council regarding the name of the form being imminently changed.
- We reviewed two uDNACPR form and both were appropriately completed and signed.
- Staff undertook Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and Dementia training as mandatory.

End of life care

Are end of life care services caring?

Outstanding



We rated EOL care as outstanding, in terms of being caring. This was because;

- Staff provided sensitive, caring and individualised personal care to patients who were at the end of their life.
- Feedback from patients and their families and stakeholders was continually positive about the way staff treated people.
- Patients felt that staff went the extra mile and the care they received exceeded their expectations.
- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Patients' privacy and dignity was maintained.
- Most patients' families felt informed about their care and supported at their relatives EOL.
- We were told about and shown collaborative working across the teams to provide good examples of care for EoLC patients.
- The chaplaincy team supported patients, relatives, ward staff and other professionals delivering EOL care.

Compassionate care

- Patients were consistently positive about the care they had received. One patient told us that the treatment 'was absolutely marvellous'. Another patient explained the service was 'absolutely outstanding'. The relatives of a patient who had suddenly deteriorated explained that they had been treated 'like royalty'. The family had been offered complementary therapies and were offered food and drinks regularly. Another family explained the care was 'second to none'. Staff were described as very informative and responsive.
- The patients we spoke with felt informed about their care. They said transition between outpatients and the ward were seamless and that communication was good.
- Patients told us that staff took time to interact with them and displayed supportive attitudes.

- Nursing staff told us if they have a lot of patients who are near EOL then providing appropriate care could be a challenge. However, the SCT often supported staff and put steps into place to address patients' needs if this occurred to ensure that patients and their relatives were supported.
- Porters explained that staff allowed families the time they needed to be with their loved ones.
- Mortuary staff told us that honouring the spiritual and cultural wishes of the deceased patient was something the porters were particularly good at.
- Nursing staff cared for patients' possessions until a patient's representative could arrange to collect them. The service was in the process of introducing holdalls for patients' belongings so families were not carrying them in carrier bags.

Understanding and involvement of patients and those close to them

- Patients told us that staff communicated with them so that they understood their care, treatment and condition.
- The service was undertaking a Macmillan project to improve patient care for breast cancer patients. This included increasing the number of open and honest conversations regarding advanced care planning in patients who had advancing breast cancer disease and partnering breast care nurses with palliative care nurses.
- A trust audit (January 2016) showed that 96% of patients had had advanced care planning discussions or goals of care discussions. However, the service had identified that further work was needed in this area to ensure that staff outside the SCT had more training to feel confident in having advanced care planning discussions at an earlier stage. An action plan was in place to address this.
- We observed staff being sensitive to patients' needs and the amount of information that they wanted sharing with their relatives.
- The service included patients and their families in decisions about treatment and care to the extent the person wanted. Documented evidence of care and support of the patient's family and those important to them during the dying phase.

End of life care

- From a recent audit, presented to the PECC in May 2016, it was identified that:

89% of relatives felt that their loved one was very well cared for in general during their stay at The Christie. On average 83% of relatives felt they were provided with enough information on a range of topics in relation to the care in last days of life. 89% of relatives felt that they were supported and looked after 'Very well' during their loved one's stay at The Christie. 83% 'Strongly agreed' that they had been treated with dignity & respect at all times. 83% had emotional support available from The Christie when needed. 67% felt 'Very well' informed with regards to their loved ones on-going treatment plan and changes to care, with 22% feeling they were 'Quite well' informed and 11% feeling they were 'Not so well' informed. 89% were involved as much as they would have liked in decisions about their loved ones care.

- Following this survey an action plan was put in place with six recommendations. Two of these recommendations had been implemented at the time of our inspection.

Emotional support

- The SCT told us that they frequently linked families to the Beechwood Bereavement services.
- If staff were concerned regarding a patients' family they offered support from the trust's psycho-oncology team or chaplaincy.
- Ward staff provided bereavement booklets to the family of a deceased patient, which provided information regarding support they could obtain and guidance for their next steps.
- Patients and their relatives could refer themselves to the Chaplain.
- The service held memorial services for patients, their families and staff on an ad hoc basis.
- The SCT had arranged weddings at very short notice for patients who requested it.

Are end of life care services responsive?

Good



We rated EOL care as 'Good' for 'Responsive'. This was because:

- Awareness of the specialist team was embedded in all clinical areas of the hospital. They were professional, responsive and supportive of patients, relatives and staff.
- Rapid discharge protocols and processes were effective in getting patients to their preferred place of care prior to their death. The discharge coordinator worked with commissioners of services, local authorities and other care providers from all over the country and abroad, co-ordinating care and facilitating access to appropriate services for EOL care patients.
- The chapel accommodated all faiths. Staff respected the cultural, religious and spiritual needs of patients.
- Symptom control was considered and well managed.
- Complaints were dealt with well and learning points were developed into actions to develop and improve the service.

However;

- The mortuary service was not available from 5pm on Fridays until 9am on Sundays. This meant that on six occasions in the last year people's faith needs after their death could not be met.

Service planning and delivery to meet the needs of local people

- At the Christie because it is a tertiary centre the data for preferred place of death as a measure is difficult to evaluate, as most patients would be discharged back to the community unless they stated their preferred place of death was in the hospital.
- The service tried to ensure that patients whose preferred place of death was at The Christie were given that preference.

End of life care

- Nursing staff told us that the SCT came round each day to see if staff needed any assistance with patients. The trust had recently introduced discretionary meal cards, which were provided by ward staff to family members who were staying with patients at EOL.
- Relatives of patients at EOL were offered the option of staying within patient's own rooms or within nurses accommodation over the road from the hospital.
- The service had a relatives' room, which was used for difficult conversations with people.

Meeting people's individual needs

- Nursing staff completed oral care for patients.
- Translation services were available within the trust.
- A bariatric trolley was available for patients.
- Nursing staff were aware of patients' additional needs at the EOL including the need for increased observations.
- Staff ensured that they respected the patient's wishes regarding the level of information that was provided to patients' families and visitors.
- Within the chaplaincy there was a multi-faith room and a prayer room. A range of faith leaders covered the chaplaincy.
- The Chaplain told us the chaplaincy team tried to tailor the service they offered to meet the individual person's needs.
- Religious services were delivered weekly by the chaplaincy service that patients could attend.
- Porters told us that they would transport patients in keeping with their religious requirements where possible.
- The mortuary service was available Monday – Friday and offered an on call service on Sunday mornings. This meant that on six occasions in the last year people's faith needs after their death could not be met. We escalated this to the trust at the time of our inspection.
- In the bereavement suite there were information leaflets on a range of subjects including bereavement counselling services, organ donation and arranging a funeral.
- The SCT accepted referrals from a range of sources including the wards, outpatients, radiotherapy and chemotherapy and the clinical trials unit. Referrals were also accepted from GPs, district nursing and community based staff.
- All referrals were triaged to establish whether the SCT or the pain management team depending on the patient's needs would best see patients.
- The SCT were sub-divided into two smaller teams, which covered different areas of the hospital. This provided continuity of care for patients.
- The team had emergency bleeps for staff to contact them for urgent referrals.
- The community link team were responsible for rapid discharges from hospital from Monday - Friday. They liaised with ward staff, the SCT, patients and their families, hospices and other services within the community to ensure rapid discharges were either the same day or the following day. Staff told us the vast majority of patients were discharged within 24 hours. On Saturdays and Sundays the SCT discharged patients.
- The community link team had a system in place to categorise discharges so they knew which needed prioritising.
- All staff we spoke with were aware of the community link team's role and how to contact them.
- The community link team ensured that patients were discharged with uDNACPR forms.
- The porters aimed to be with a ward within 12 minutes of receiving a request to transfer a patient. Porters told us they were flexible regarding relatives' needs when they were transferring a patient
- Staff reported they had a good working relationship with North West Ambulance Service and could obtain an ambulance for a discharge within two hours.
- 99% patients were seen within 24 hours of being referred.
- Concerns were expressed that the services other ambulance provider, did not have many stretcher vehicles and that this resulted in delays until the end of the day for discharges. We escalated this within the SCT at the time of our inspection.

Access and flow

End of life care

- The trust collated information from patients regarding their preferred place of death. The main site was a tertiary centre that accepted patient referrals from other providers. As such, in most cases, patients were discharged back to their local hospital / hospice or into the community for EOL care.

Learning from complaints and concerns

- The hospital had clear policies and protocols for the management of complaints and concerns.
- Staff were aware on how to support patients and people close to them, when dealing with concerns and complaints. There were processes in place to learn from complaints.

Are end of life care services well-led?

Outstanding



In terms of being well-led, we rated EOL care as outstanding because;

- There was a clear EOL care strategy and the management team understood the vision of achieving this.
- The SCT had governance and quarterly review meetings involving others, where appropriate.
- The trust's culture encouraged candour, openness and honesty.
- The service were undertaking many initiatives and trials to improve EOL care for the patients they cared for.

Vision and strategy for this service

- The service had a clear vision and a set of values that focused on quality and safety. The SCT aimed to be the '4th pillar' of core business at The Christie alongside surgery, radiotherapy and chemotherapy: to provide integrated, multidisciplinary and cutting edge treatments in all aspects of supportive care for people with cancer.
- At The Christie, they had recently changed the focus of palliative care, as they felt able to make a positive difference to the care for patients at a much earlier stage. The SCT worked with all clinical teams to ensure that for those patients who were approaching the last

weeks/days of life, there was high quality compassionate care for them and their families. The SCT supported the SCN and Manchester Cancer palliative and end of life care strategy.

- The SCT felt that their role in a major tertiary cancer centre provided them an important opportunity to influence the experience of many other patients, whether they were ultimately cured of their cancer or have to live alongside this. As such, they aimed to expand their work alongside oncology teams, to enhance patient care and experience; and work as one integrated team, with their colleagues in pain and psycho-oncology, so that the care was truly seamless and multidisciplinary.
- The service had created a robust, realistic strategy for achieving the priorities and delivering good quality care.
- Staff we spoke with within the SCT were clear on the vision and values. Outside the SCT, staff members' knowledge depended on who they were and the level of involvement they had had from SCT members.
- All staff we spoke with were clear how to provide EOL care and of the importance of it within their role.
- The SCT regularly presented EOL at various committees including Risk and Governance, Patient Safety, Patient Experience, Quality Assurance, Governor's Quality Committees and Acute and Critical Care Directorate. The presentations have addressed how The Christie has responded to the withdrawal of the LCP, implementation of One Chance to Get it Right and the 5 Care Priorities, audit findings and associated action plans.

Governance, risk management and quality measurement

- The service had a clinical lead, service improvement lead and an active board member with EOL care responsibilities. The Director of Nursing and Quality was the named person on the trust board with responsibility for EOL care. There was also an active lay member on the trust board with responsibility for EOL care. Staff were aware who these people were.
- EOL care was given sufficient priority at board level which enabled service development.

End of life care

- The SCT had weekly meetings before their MDT meeting to discuss governance issues.
- Members from the SCT attended the monthly patient experience committee, which was chaired by a doctor within the team.
- The team were represented at the acute and critical care monthly meetings. The person who attended then fed back to the SCT.
- The division had a monthly clinical governance meeting, which covered risk registers, mandatory training rates, appraisal rates and other governance issues.
- Each Thursday the SCT had a work based learning event where they completed an educational presentation as part of a rolling programme.

Leadership of service

- There was strong leadership at board level supported by nursing and medical staff within the SCT.
- We found the trust was committed to delivering excellent EOL care for all patients.
- The SCT leadership team were of a high standard and this was confirmed by all of the staff we spoke with. The leadership we spoke with told us they were proud of their team that were committed to deliver high quality care for EOL care patients.
- SCT leaders worked within the team and were visible in outpatient clinics and on wards.
- Service leaders had a good understanding of the challenges their services faces and demonstrated a range of evidence outlining actions they had taken to address them.

Culture within the service

- At the main site there was a 'curative' culture. Most staff described the culture positively and felt supported and that they could confidently contact senior staff if their assistance was required. However, the porters we spoke with reported that morale was low as they did not feel listened too when they expressed concerns.
- We observed a committed and caring group of staff within the specialist team. Staff were clearly committed

to providing good EoLC for patients and felt valued by their managers and appreciated for how hard they worked. They were proud of the work their colleagues and department did.

Public engagement

- The SCT consulted the patient experience committee (PECC) regarding various ideas that they had. They sought feedback and acted upon it before introducing new ideas e.g. they considered introducing a symbol but the PECC did not feel it was appropriate so the SCT did not introduce it.
- The SCT had a volunteer who worked closely with them. They obtained patient feedback by carrying out patient surveys.
- The team sought feedback from patients' families but ensured they did this in a sensitive manner. They avoided sensitive times of year (Christmas) even if this then reflected poorly on them in national surveys.

Staff engagement

- Staff had the option of reduced price complementary therapies.
- The service encouraged staff to take part in the mentorship programme.

Innovation, improvement and sustainability







- The SCT were highly commended in 'The Christie Team of the Year 2015 - best outcomes category'.
- The school of oncology ran courses four times a year on AaND form completion and identifying the right time to do this.
- The nursing lead had a went to two leading cancer specialist services in America to observe best practice. As a result she brought back ideas for improvements, some of which were being implemented at the time of our inspection.
- The service was initiating the 'goals of care' approach to help ensure that clinicians and patients truly understood each other's expectations regarding treatment and outcomes. At the time of our inspection, a small number of conversations had been trialled with patients. Clinicians told us that they found the approach ensured that conversations were easier to have and that they truly understood what their patients expected from

End of life care

them in their patient journey. Service leads were preparing to present this to the Cancer Vanguard for consideration for 'goals of care' being rolled out across the country.

- The team had worked to develop the 'Enhanced Supportive Care' initiative. This is a new initiative aimed at addressing more fully the needs of cancer patients. The doctor is the national lead for this initiative, which is now being rolled out by NHS England. The service received a national QIC (Quality in Care) patient care pathway award in February 2016 for this service.
- The service participates in a number of clinical trials on palliative and supportive care measures including hydration in the last days of life.
- The SCT had collaborated with another trust to develop electronic training modules for staff, which were due to be launched shortly after our inspection. This included an End of Life Care and a Pain Management module amongst other subject modules. The programme aimed to provide an evidence-based one-stop user-friendly on-line learning portal to support busy nurses to assess, develop and assure themselves of their knowledge across core areas of fundamental care. It also provided a Trust with an opportunity to assure the public and other stakeholders that its nursing workforce is up-to-date, and practicing caring and compassionate evidence based care.
- The service had participated in a national feasibility study for nutrition and hydration in the last days of life.
- The service was undertaking a Macmillan project to improve patient care for breast cancer patients. This included increasing the number of open and honest conversations regarding advanced care planning in patients who had advancing breast cancer disease and partnering breast care nurses with palliative care nurses.
- The service were working with their IT department to develop an electronic system to allow all GPs (not just those within Greater Manchester) to receive information electronically regarding their patients.
- The service was planning Phase 2 of the Enhanced Supportive Care – Predict and Prevent to be implemented across the Trust. This will involve the development of a supportive care unit to provide a daily supportive care outpatient service.
- Members of the team are Clinical Directors for Manchester Cancer LWBC and Palliative Care Boards and currently working on Cancer Vanguard proposals.
- At the time of our inspection the service were about to introduce provision of a holdall for patients' belongings so family members could use them instead of carrier bags.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient and diagnostic imaging services are provided by The Christie NHS Foundation Trust at The Christie main site, under the Cancer Centre Services division. The Christie is an international centre of excellence for cancer care.

The main outpatient department is located on the ground floor of the hospital, providing a range of clinics including; urology, colorectal, breast, haematology, oncology, maxilla-facial, plastics, ovary, lung, brain, anal, lymphoma, gastro-intestinal, endocrine, head and neck, thyroid, gynaecology, dietetics, skin and testes.

Between September 2014 and August 2015 the hospital accommodated 487,808 appointments (an average of 1336 patients each day). Approximately 6% of appointments were first appointments.

Diagnostic imaging services are provided within the hospital. The department has four direct radiography (DR) rooms (one of which includes a orthopantomogram (OPT) machine), two computed tomography (CT) scanners (with an additional scanner shared with radiotherapy planning), a single interventional suite, three gamma cameras, one positron emission tomography-computed tomography (PET CT) scanner, two magnetic resonance imaging (MRI) scanners, and one diagnostic ultrasound room.

During our inspection we spoke with 26 patients and 35 members of staff including clinical directors, service managers, radiation protection supervisors, staff nurses, senior nurses, clinical specialist nurses, radiology supervisors and advisers, radiographers, radiologists, receptionists, and junior doctors. Prior to the inspection we

held a listening event where we spoke with 88 patients and visitors in clinic waiting areas. We also reviewed five patient records and analysed information provided by the trust before and after our inspection.

Outpatients and diagnostic imaging

Summary of findings

We have rated outpatient and diagnostic imaging services as good overall. This is because:

- There was a culture of reporting and learning from incidents amongst staff. All but one incident was reported as low or no harm.
- A radiation protection service was in place to support and supervise diagnostic imaging practice.
- Most of the areas we viewed were visibly clean and tidy. Regular audits ensured cleaning and infection control practice such as hand hygiene was maintained. Results showed 100% compliance. Rooms and waiting areas were fit for purpose, although some clinic rooms in outpatient areas were small. Infrastructure was reviewed and refurbished when required. Equipment was in good working order and checked regularly.
- Medicines and diagnostic imaging chemicals (such as contrast) were stored correctly. Records were stored appropriately, legible and contained appropriate patient detail.
- Staff were compliant with mandatory training including safeguarding. There were processes to support staff highlighting concerns. Senior staff received training for major incidents where appropriate.
- Services managed potential risks to patients with processes to identify and provide treatment if patients became unwell. There was appropriate supervision in diagnostic imaging areas.
- Staffing levels were adequate and regular meetings enabled managers to share information. Care and treatment provided by staff was evidence based, with regular research undertaken.
- Diagnostic imaging staff used policies and procedures as required by Ionising Radiation (Medical Exposures) Regulations 2000. Regular discrepancy meetings ensured radiology reporting standards were maintained.
- Staff at all levels had opportunities to develop and maintain competency in roles through induction, supervision, and assessments. Annual appraisals were completed with the majority of staff up to date.
- Multi-disciplinary care was provided, both internally and regionally. Whilst services were provided

between Monday and Friday, extra hours were added if capacity issues arose. Radiology reporting was available out of hours. Staff accessed information about patients when required and diagnostic imaging staff had access to regional imaging systems enabling sharing between NHS trusts.

- Staff worked on the basis of implied or verbal consent day to day, and written consent for more invasive procedures.
- Feedback was continually positive about staff. They described staff listening to them, taking time to consider needs and address concerns. Staff showed a willingness to listen before answering questions honestly. We saw staff interacting with patients, recognising needs and providing kind, considerate care.
- The Christie Information Service provided a wide range of information including types of cancer, nutrition, treatments and wig providers. A hotline telephone service was available 24 hours a day, seven days a week providing advice and support to patients and loved ones. Information leaflets were also available.
- Staff were familiar with local and individual needs and care was delivered with this in mind. Transport, translation, chaplaincy, and free Wi-Fi helped to ensure patients' needs were met. Complementary therapy was also available for patients and those close to them.
- Measures were used to maintain standards. Targets to provide timely care were consistently met. Waiting time, delays and cancellations were minimal given logistic challenges. However, staff took the time to investigate and manage issues relating to delays.
- There was a process in place for people to complain or raise concerns. Minimal numbers of complaints were received.
- Services had a vision and strategies in place to improve services which were progressing. Risk registers were used to monitor risks which fed into service delivery plans. Governance meetings took place regularly.
- Staff liked their managers, describing an 'open door' approach. Leaders visited staff and worked with

Outpatients and diagnostic imaging

them. The culture placed an emphasis on person centred care, and preventative multi-disciplinary treatment and support. Staff felt privileged to provide care for patients in a supportive culture.

- Engagement with the public such as school visits took place. Senior managers described visiting patients in waiting areas to review services from their perspective. Staff engagement was evident with dedicated sessions provided for staff to share stories and support each other, and initiatives to maintain motivation.
- Clinical trials to find new and effective treatments for cancer were always in progress. Exploration of ideas to improve flow also took place and accreditation schemes formed part of future plans.

However:

- The sickness rate for nursing staff was higher than the NHS average.
- We found some medicines being stored at higher than appropriate temperatures. Storing medicines at high temperatures can affect their efficacy.
- Whilst interventional radiology staff used the World Health Organisation Safety Surgical Checklist to help manage the risk to patients undergoing these procedures, staff did not always use it.

Are outpatient and diagnostic imaging services safe?

Good



We have rated outpatient and diagnostic services as good in the safe domain. This is because:

- There was a culture of reporting and learning from incidents amongst staff. All but one incident was reported as low or no harm. A radiation protection service was in place to support and supervise diagnostic imaging practice.
- Most of the areas we viewed were visibly clean and tidy. Audits were done regularly to ensure good cleaning and infection control practice. Results showed 100% compliance. Rooms and waiting areas were fit for purpose. Infrastructure was reviewed and refurbished when required. Equipment was in good working order and checked regularly. Medicines and diagnostic imaging chemicals (such as contrast) were stored correctly.
- Records were stored appropriately with legible, thorough details about patients filed in an organised way. Staff trained in safeguarding and processes were in place to support the referral process and high numbers of staff were up to date with mandatory training.
- Services managed potential risks with processes to identify and treat acutely unwell patients. Appropriate levels of supervision were in place in diagnostic imaging areas to ensure radiation was used safely.
- Staffing levels were adequate and regular meetings took place to ensure information was shared amongst staff. Senior staff received training for major incidents when appropriate, and knew what process to follow should a major incident be declared.

However:

- The sickness rate for nursing staff was higher than the NHS average.
- Whilst interventional radiology staff used the World Health Organisation Safety Surgical Checklist to help manage patient risk, staff did not always use it.
- Some medicines were being stored in rooms which were outside of suitable temperature range.

Incidents

Outpatients and diagnostic imaging

- There was a culture of reporting and learning from incidents amongst staff. Staff used a web based incident logging system which produced electronic receipts and outcomes. Staff we spoke to knew how to log an incident on the system.
- Between April 2014 and March 2015 the main outpatient department reported 142 incidents. All but one of these were categorised as minor or no harm. The diagnostic imaging department reported 104 incidents, most of which were deemed “no harm” or minor harm to the patients. The most frequent of these related to extravasation, (where contrast or other intravenous drugs leak from the veins into surrounding tissue).
- Staff identified occasions when unjustified imaging requests were made. We saw that processes were in place, with staff contacting referrers when potential errors were identified.
- Only two incidents occurred in 2015 where patients received doses of radiation ‘greater than intended’. These both related to low dose examinations being carried out when not required.
- No never events were reported between February 2015 and January 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. One serious incident was reported which related to an apparent, actual or suspected incident of self-inflicted patient harm.
- Comprehensive root cause analysis took place following serious incidents which included action plans to limit recurrence. For example, following a patient becoming unwell prior the start of clinic, a senior nurse changed her working hours to ensure there was nursing cover when the department doors opened each day.
- We saw evidence that learning took place for staff involved and in wider teams where learning was shared. Outcomes following outpatient incidents were shared at daily staff ‘huddle’ meetings held before clinics.
- Formal debrief meetings took place following some incidents, including staff who attended to assist.
- Staff were aware of the Duty of Candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Radiation Protection

- The Christie Medical Physics and Engineering (MPE) department supported diagnostic imaging staff by providing radiation protection services.
- The team included radiation protection supervisors, advisors (as required under Ionising Radiation Regulations 1999 [IRR99]), medical physics experts (as required under Ionising Radiation (Medical Exposures) Regulations 2000 [IR(ME)R]) and radioactive waste advisors.
- Supervisors received regular updates from the MPE team. We saw strong relationships between advisors and supervisors. For example, staff were supported when sharing or testing equipment with expert opinions provided when required.
- The Medical physics team regularly provided comprehensive reports. These were shared at the Radiation Protection Committee which met bi-annually, with a more detailed report shared annually.
- Dose audits and optimisation tests were carried out regularly. Whilst diagnostic reference levels (DRLs) were above national levels, justification was in line with clinical evidence.
- Plain film radiographers had minimal knowledge of DRLs, however CT radiographers were very knowledgeable, providing clinical evidence using higher than national levels.
- We saw radiation protection documentation in the plain film department which fulfilled IR(ME)R and IRR99 requirements. These were reviewed regularly, with staff compliance audited annually.
- We saw no evidence of paediatric optimisation. However, the department saw only very small numbers of children and staff received training and showed knowledge about dosage.
- Procedures were in place (as specified by IR(ME)R) to ensure exposure to radiation was kept as low as reasonably possible.
- We found a minor discrepancy regarding IR(ME)R employers’ procedures where the operator was cited as being responsible for justifying examinations. Whilst this posed no risk to patients, it contravened IR(ME)R regulation.

Cleanliness, infection control and hygiene

Outpatients and diagnostic imaging

- The areas we visited were visibly clean and tidy except a sluice room in the outpatient department where the floor appeared dirty.
- Cleaning took place daily by domestic staff. Clinical staff disinfected areas each day using chlorine based wipes.
- Whilst staff used schedules to ensure areas were cleaned regularly, they did not record what cleaning had been done, which meant we could not corroborate what staff told us. Despite this we saw staff cleaning areas and equipment throughout our inspection.
- Staff adhered to hand hygiene practice, washing hands and using sanitising gel which was available in clinic rooms, main waiting areas and in radiology. Where we found one empty gel dispenser, it was quickly refilled by staff.
- Monthly hand hygiene audits were carried out in outpatient and diagnostic imaging areas. These showed 100% compliance in October, November 2015, and January 2016. No data was provided by either department in December 2015.
- A noticeboard in the main outpatient waiting area displayed information about infection prevention and control. Details included results of hand hygiene audits in the department (April 2016 was displayed showing 100% staff compliance), information leaflets about hand washing and types of infection as well as the name and contact details of the department link nurse, (link nurses share information and provide communication between specialist teams and nurses in clinical areas).

Environment and equipment

- Diagnostic imaging and outpatient areas were well lit and free of clutter. They were welcoming with plenty of seats, water and vending machines. Some waiting areas had music playing in the background.
- The main outpatient areas were based in an older area of the hospital building. Clinics were held in numbered areas. The main outpatient area (department 42) consisted of five suites, each with a number of clinic rooms totalling 15. Other clinics were held in department 35 which had two other suites with 11 clinic rooms in total.
- In the waiting area of Department 42 high ceilings gave a feeling of light and space. Colour coded areas helped direct patients to the right seats. For example patients awaiting blood tests sat on purple chairs, those waiting for transport waited on brown chairs. However there was limited space to care for patients who became unwell in the department. Staff managed by refurbishing an office to make it onto a treatment bay, which was in progress at the time of our inspection.
- Department 35 was smaller in comparison and with lower ceilings and no outside light. It appeared to be less spacious and we were concerned that wheelchair access to toilets may be limited by chairs in the waiting area. However, we saw that investment had been secured for improving outpatient services which included new build plans.
- We saw that there was plenty of space in diagnostic imaging areas. Patients receiving radiopharmaceutical drugs waited in a designated “hot waiting area” following administration. This helped avoid visitors and other patients being exposed to radiation.
- Clinic and changing rooms had emergency call bells.
- Outpatient staff completed equipment checks, using written guidance with photographs to help them check equipment correctly. We checked a range of equipment such as defibrillators, oxygen cylinders and resuscitation trolleys. All items were visibly clean and ready for use. Records showed checks were up to date and equipment was in working order. Service logs we reviewed were up to date.
- The diagnostic imaging department had a comprehensive equipment inventory including installation dates and equipment servicing information which complied with IR(ME)R. Some imaging equipment was due for replacement. This was addressed in an up to date service delivery plan. All other equipment was included in a rolling replacement programme.
- As part of the current replacement programme, the department was purchasing a new Magnetic Resonance Imaging (MRI) scanner and building a new interventional and vascular suite. The department had recently purchased a new image intensifier, following increasing unreliability with older equipment which was noted on the risk register.
- Daily quality assurance (QA) and service work was undertaken in diagnostic imaging areas. Records showed this was up to date with recommendations actioned.
- Areas and equipment were reviewed with action taken to improve when required. For example, in January 2016, an audit undertaken in the computed tomography (CT) department showed only 60% compliance with good practice. This was because areas required

Outpatients and diagnostic imaging

repainting and some equipment was in disrepair. Refurbishment took place and was in progress at the time of our inspection. We saw that work did not impact on the provision of services.

- The outpatient physiotherapy team had a mock 'assessment bathroom' where patients were assessed for the provision of equipment for their home. This included bath and toilet seats, steps and hand rails. Here staff individually assessed patients to ensure their needs were met.

Medicines

- A range of medicines and controlled drugs were stored in outpatient areas. No drugs requiring storage at low temperature were used.
- Medicines were within expiry date and stored in an organised and secure way using digital locking and key entry systems. Isotopes (radioactive chemicals which improve diagnostic images) were stored safely, with shields and protective equipment readily available. Some isotope doses were drawn up automatically which helped reduce exposure to staff.
- Staff checked controlled drug stocks regularly to ensure anomalies were identified. Checks were recorded correctly.
- One of the outpatient rooms storing medicines had a temperature of 30 degrees. Medicines should not be stored in rooms of this temperature. Staff told us the room temperature was recorded daily because it was known to be warm. We saw readings of between 20 and 30 degrees each day. We advised senior nurses about our concerns who immediately escalated the issue to pharmacy staff. We saw that plans were already in place to mitigate the risks of high room temperatures, with regular assessment and stock rotation. Longer term solutions such as air conditioning were also under review.
- Clinical nurse specialists and medical staff in outpatient areas prescribed medicines to patients. Nurses trained to prescribe attended twice yearly meetings and practice was audited twice each year. Other outpatient staff did not require this qualification as prescriptions were provided by medical staff during clinics. Prescribing forms were locked away in a secure area of the department.

- Some radiography staff issued medicine using Patient Group Directives. PGDs allow non-medically trained staff to administer certain drugs including x-ray contrast without the use of prescriptions. We saw that these were up to date.
- Radiology patients requiring contrast (chemicals which improve pictures of the inside of the body) were screened using safety questionnaires. Risks and potential side effects were also discussed with patients prior to administration.
- Checklists were used to help protect patients from drug reactions. Anaphylaxis flow charts were displayed ensuring staff could see them quickly in case of emergency.

Records

- Outpatient records were in paper format with duplicate details stored electronically.
- Paper records were delivered the night before clinic and stored securely overnight in a locked room. During the day records were kept behind the reception area with staff present at all times or in a room where only staff were present.
- Staff had a process for checking patient records each morning. Missing records were identified and contact made with departments to try to locate them. If paper records were not available, staff generated a temporary record from the trust's electronic patient record system which contained duplicate details.
- We asked how often records were not available or missing for patients attending appointments. Records showed that on one day in May, ten records were missing, six were missing the following day and four the day after that. However there appeared to be no impact to patients. Managers and administration staff could not recall a time when appointments were cancelled because records were not available in either paper or electronic format.
- We looked at five outpatient records during our inspection. Notes were in chronological order and legible with staff names documented. They included attendance date and time, and appropriate background detail including risk assessments and consent where required.
- Radiology records were electronic and stored on a system linked to a patient archiving communication system (PACS).

Outpatients and diagnostic imaging

- Staff worked on both systems to ensure examinations were processed and reported in a timely manner.
- There was a process to transfer images to other hospitals upon request. All staff were trained to do this which limited delays. The trust participated in regional discussions to help improve image sharing between trusts.
- Imaging requests were made electronically by trained staff who were audited to ensure practice was correct. Since the introduction of electronic requesting, the department had seen a decrease in referral errors.
- Electronic request forms included a safety checklist (including related blood results, allergies, and infections) and confirmation of whether patients were on clinical trials. Requests were printed and then destroyed following examination.
- Some examinations (approximately eight each day) were done as part of clinical trials. Staff managed their contribution and the timeliness of examinations for trials through an on line clinical trial tracking system. Staff justified exposure to radiation for clinical trials and kept up to date with trial progress with trust posters and through the tracking system.
- Mandatory training covered topics including basic life support, equality and diversity, information governance, moving and handling and fire safety. There was additional mandatory training in radiation protection and magnetic resonance imaging safety awareness for diagnostic imaging staff.
- 93% of outpatient nursing staff were up to date with mandatory training which fell just below the trust target of 95%. Figures were lower for administration staff who only had 60% compliance. Despite the low compliance figure overall, administration staff were 100% compliant in eight out of 12 topics. However because none had completed training in anti-fraud awareness, equality and diversity, health and safety and information governance the overall rate was low.
- Training figures for diagnostic imaging staff showed that 97% of computed tomography, interventional and plain film staff, 98% of non-ionising imaging staff and 94% of nuclear medicine staff were compliant with training. All staff except healthcare scientists (with 94%) were compliant with infection prevention and control training.

Assessing and responding to patient risk

Safeguarding

- Safeguarding training was mandatory. Staff completed different levels of training based on their level of contact with patients.
- Managers told us that all outpatient nursing staff were up to date with level two safeguarding training and this was confirmed with figures provided by the trust. In the diagnostic imaging department, all clinical, administrative and support staff were compliant with level one safeguarding training.
- A lead safeguarding representative was available for staff, should they have any queries or require support.
- Safeguarding information was displayed including processes to follow and contact details for raising concerns. Specialist nurses described this process and having 'a clear pathway' where they knew their responsibilities. They also described feeling supported by the lead safeguarding nurse. However staff also said they relied heavily on the lead, and were not always aware of cover arrangements for her during periods of absence.

Mandatory training

- Processes were in place to manage risks to patients such as worsening conditions or urgent findings.
- Clinic and changing rooms had emergency call buttons to summon help should a patient need assistance.
- We heard examples where staff identified deteriorating patients and took action to provide emergency treatment.
- Managers told us that all staff underwent hospital life support training and all nursing staff and above underwent higher hospital life support training. However figures provided by the trust showed that only 55% of staff were trained in basic life support and defibrillation, and only 60% were trained in Hospital Essential Life Support.
- A "baton bleep" system was used to summon medical staff urgently. For example, to provide emergency care or provide urgent incidental findings following scans. The bleep system operated from Monday to Friday between 9am and 5pm. Outside of these times a call could be made to a medical doctor on call via the trust switchboard.

Outpatients and diagnostic imaging

- Emergency resuscitation equipment was available in all areas, with a dedicated paediatric trolley in the CT viewing area for children undergoing general anaesthesia. We saw that trolleys were checked regularly with monthly audits done to confirm this.
- Oxygen was available throughout outpatient and diagnostic imaging areas. All oxygen cylinders in radiology areas were full. Where we found low levels in one cylinder in the outpatient area, staff took immediate action to replace it.
- Radiation protection supervisors (RPS) were available for each diagnostic imaging modality. These staff supervised radiographers, ensuring necessary work was undertaken and procedures and protocols were followed.
- Policies and procedures were all held on the shared computer drive which helped ensure accessibility. There were in depth lists of examination protocols, scope for referrals, and guidance for practitioners to aid justification of examination requests.
- Exposure charts were available for staff which reduced the risk of over-exposure. These were in paper format but had not been reviewed since 2008. Whilst equipment upgrades had taken place since then with exposure pre-programmed into them, we were concerned about the risk of staff referring to out of date exposure values by mistake.
- Radiation risk assessments were undertaken annually. All the assessments we reviewed were up to date.
- The department used the World Health Organisation surgical safety checklist (WHO checklist) when patients underwent fluoroscopy guided, ultrasound (US) guided or computerised tomography (CT) guided intervention procedures. Use of the WHO surgical safety checklist was first recommended in September 2015. Whilst the trust had implemented this, audits showed poor compliance with only 75% of staff documenting use of them across all modalities (30% in CT, 32.5% in US, 15% in fluoroscopy). Of those that were documented, only 82% of US and 67% of fluoroscopic procedures were fully completed (with CT the exception with 100%). However, the department recognised this and staff were working to establish the root cause of low compliance scores, share results and put actions in place.
- Staff were assigned to different areas of outpatient and radiology departments in an organised way. Staff worked in teams which ensured lone working was kept to a minimum.
- In the outpatient department, three senior nurses, seven staff nurses, 25 healthcare assistants and a housekeeper were employed on either a part time or full basis.
- Acuity tools were not used to calculate staffing requirements. Instead work had been done by managers to accurately assess the needs of each clinic and staffing levels were then entered into a monitoring tool which alerted them if numbers fell below what was considered appropriate.
- Outpatient staffing was done equitably with a mixture of early finishes and late finishes on different days.
- Annual leave was managed to ensure clinics were not left understaffed at short notice.
- In the diagnostic imaging service, there were 2.6 whole time equivalent nurse vacancies and no vacancies for additional clinical staff (such as healthcare assistants). In the outpatient department, there was one whole time equivalent outpatient nurse vacancy and 0.4 whole time equivalent vacancy for additional clinical staff.
- Short falls in staffing were covered by agency staff if required. Between April 2014 and March 2015, average agency use in outpatients was 8%. Figures were not provided for radiology agency staff use.
- Sickness rates were monitored. Between April 2015 and March 2016 the sickness rate for outpatient nurses was 10% which was higher than the average NHS sickness rate (4.4% between January and March 2016). In radiology the rate was 1% for nurses and 2.5% for additional clinical staff.
- During the day, the rotational radiographers in CT work alongside the specialist cross-sectional imaging radiographers.
- Daily outpatient meetings took place ensuring staff received information relating to the department, incidents, or complaint outcomes.

Medical staffing

- Outpatient services did not employ medical staff. Instead medics came from each specialty to deliver clinics. All the outpatient staff we spoke to told us there were no medical staffing issues during clinic times.
- Medical staff did work in the diagnostic imaging service. The service provided two levels of on-call cover 24 hours

Nursing staffing

Outpatients and diagnostic imaging

a day, seven days a week. The first on-call person came from a joint specialist trainee rota with another local NHS Trust. A Christie radiologist consultant provided secondary on-call with expert advice. All computed tomography (CT) scans were justified by a radiologist.

- No radiology locum medical staff were used by the trust between April 2014 and March 2015.

Major incident awareness and training

- The hospital was not a receiving hospital for major incidents. Should an incident occur nearby, managers explained that emergency services would admit patients to the nearest receiving hospital.
- Despite this on call managers in the trust did receive emergency preparedness training.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Although we inspected services under the effective domain we are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging. However we found that:

- Care and treatment provided by staff was based on evidence with research undertaken to measure progress.
- Diagnostic imaging staff used policies and procedures as required by Ionising Radiation (Medical Exposures) Regulations 2000. Regular discrepancy meetings took place to ensure radiology reporting standards were maintained. Staff at all levels had opportunities to develop through further education.
- Services worked to ensure staff were competent in their roles through induction, supervision, and assessments. Annual appraisals took place and the majority of staff had received an appraisal within the last year.
- Care was provided on a multi-disciplinary basis, both internally and regionally, with specialists working in other trusts and teams meeting to discuss care for patients.
- Whilst services were generally provided between Monday and Friday, extra hours were added if capacity issues arose. Radiology support such as reporting was available on an on-call basis.

- Staff could access information about patients when required. Diagnostic imaging staff had access to a regional picture archiving system, enabling the viewing of scans across the region on one system.
- Staff worked on the basis of implied or verbal consent with day to day procedures such as blood taking. However, for more complex or invasive procedures, written consent was sought.

Evidence-based care and treatment

- Care provided in clinics was based on evidence. For example, the speech and language therapy team provided early intervention therapy based on international evidence which showed early access to therapy improved eating outcomes. Further research was in progress to help evaluate the first phase of early intervention.
- Diagnostic imaging staff used policies and procedures required by law under IR(ME)R and IRR99. These were available on a shared computer drive.
- Staff compliance with imaging policy and procedure was subject to annual audit which helped ensure staff knowledge remained up to date. Gaps in compliance were reviewed with training provided in lunch time sessions.
- Reporting standards for radiologists was high. All examinations were reported to local standards where measurements were taken under a range of cancer markers.
- As part of a rolling audit programme, the imaging department obtained annual referrer feedback. Referrers rated areas such as timeliness of investigation and reports, quality of reports and approachability of staff. The 2016 results showed positive results with 92% being rated excellent or good for timeliness of reports and the overall department being rated excellent by 53% and good by 42% of referrers.
- Discrepancy meetings took place. These meetings allowed staff to identify errors or discrepancies in radiology reports. Royal College of Radiologist guidelines state that radiologists should have a minimum 50% attendance rate and that meetings should take place at least every two months with a bi-annual report documenting key learning. The department complied with this. Meetings included reporting radiographers which formed part of their appraisals.

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Pain relief

- Three and a half whole time equivalent staff worked in a pain management team. This included one consultant and clinical nurse specialists.
- The team had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015) and adopted a number of recommendations made regarding standards in specialised services. These included having dedicated pharmacy input, input from other specialists (such as the palliative care team), engagement with audit, timely access to pain relief and a pain assessment tool.
- Pain clinics were held by a specialist support team to help people manage pain and other symptoms. Audits were completed to monitor how well people adhered to medicines to manage pain. The latest audit was completed in January 2016 and showed that 93% of patients audited (14 patients) were taking pain relief medicine in the right way.

Patient outcomes

- Outpatient staff were not responsible for running clinical trials or undertaking clinic audit. However, they regularly worked with and assisted specialist teams who were.
- Each speciality was involved in research to measure outcomes for patients and find new avenues for treatment. For example, in February 2015 staff from the head and neck specialty measured survival rates in patients treated at the hospital with one or a combination of chemotherapy, radiotherapy and proton beam therapy. These showed a one year survival rate of 88% for patients with cancer of the larynx. The rate for patients with cancer of the pharynx or oral cavity was 77%. The gastro-intestinal specialty assessed survival rates amongst patients with upper-gastrointestinal cancers in 2013, based on their level of activity. Results showed that greater numbers of fully active patients survived for longer than numbers of less active patients.
- The diagnostic imaging department was not participating in the Imaging Services Accreditation Scheme (ISAS) at the time of our inspection. This patient-focussed assessment and accreditation programme ensures patients consistently received high quality services, delivered by competent staff working in safe environments. Staff told us the department had prioritised other service delivery plans instead.

Competent staff

- New radiography staff underwent a three month induction programme, during which time competency assessments were completed. Junior doctor trainees underwent a six-week period of close supervision.
- Staff also received system and equipment training during induction. For example, diagnostic imaging, physiotherapy and occupational staff received specific training for specialised equipment. Records showed staff were up to date with equipment competencies.
- There were opportunities for elective student radiographers to work with senior staff to gain experience.
- Diagnostic imaging staff used a training matrix, which helped identify training requirements.
- Continuing professional development (CPD) and further education for radiographers was a key strategy within the department. Staff had three protected days each year for CPD.
- Lunchtime lectures on various diagnostic imaging subjects were held regularly and were well attended.
- Staff also had access to university courses to aid development through a staff education programme. For example, healthcare assistants could develop clinical skills through a national diploma, clerical staff could undertake a diploma in medical administration and radiographers undertook a post graduate certificate in chest x-ray reporting.
- However other radiographers described a lack of career progression at the Trust.
- Outpatient staff rotated around clinics to maintain competency in all areas. Their personal staff folders showed evidence of competency in areas such as mental capacity act knowledge and venepuncture.
- Staff received annual appraisals to review work, set targets and provide support. Between April 2014 and March 2015 100% of clinical outpatient staff and 92% of radiology staff had received their appraisal against a target of 95%.
- Revalidation for nurses was monitored by the trust. Managers received monthly reports about staff who were due to revalidate in the upcoming 3 months. Staff training was provided to introduce the topic of revalidation and help inform nurses about requirements. We saw that in July 2016, 210 nursing staff attended training. An external review of the trust's

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preparedness for nurse revalidation was completed in March 2016 and found high assurance that the trust acknowledged and understood its role in the process of revalidation.

Multidisciplinary working

- Multi-disciplinary work was the basis of outpatient clinics. Here, a range of staff ensured patients were assigned to the correct areas, blood samples were taken, assessments and treatment plans were put in place, queries were answered and patient deterioration identified.
- Specialist clinical nurses worked with medical staff to provide care for patients during clinics. They were also part of weekly multi-disciplinary team meetings to discuss the care of patients.
- Some specialists worked with colleagues at other sites to provide care. For example, head and neck clinicians undertook clinics for patients in a neighbouring trust.
- Staff from the head and neck department referred patients to speech therapy staff who provided early intervention speech therapy.
- Pathology services had been provided in partnership with a private sector company since 2014. Services included histopathology (diagnosing tumours) and blood sciences such as haematology, stem cell processing and blood transfusion.
- Surgical and oncology staff worked together to provide treatment for patients with gynaecological cancers.
- Radiologists aimed to attend approximately four multidisciplinary team meetings (MDTs) each. Three radiologists were assigned to each specialty (although reporting of results was shared amongst all radiologists).
- Radiologists had strong links with other specialist cancer trusts, fostering relationships to aid multidisciplinary team work and leadership advice. There were also plans to benchmark services.
- We saw excellent working relationships between radiologists, radiographers and radiography aids. Staff told us colleagues were always approachable, utilising each other's expertise and promoting pathways.

Seven-day services

- Outpatient clinics operated Monday to Friday from 8am until 6pm. There were no plans to expand the service into evenings or weekends.

- Diagnostic imaging opening hours generally operated in line with outpatient clinics, from 9am until 5pm Monday to Friday. However, staff in the magnetic resonance imaging area worked longer days between 7:30 and 8:30pm. Additionally, some computed tomography (CT), magnetic resonance imaging (MRI) and interventional examinations took place at weekends if capacity issues arose. Team leaders kept records of this which were reviewed monthly to ensure issues were communicated to managers.
- Outside of these hours, services were provided with an on-call rota which ensured a radiographer and radiologist were available at all times should urgent scans or procedures be required.

Access to information

- Staff accessed patient details via paper patient records or from the trust's electronic patient system.
- Diagnostic images were available on a regional picture archiving communication system (PACS).
- Clinical nurse specialists told us they felt able to approach colleagues in other departments to ask for information or seek advice about patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to an up to date trust policy about assessing mental capacity as well as the process for seeking authorisation to deprive a person of their liberty. The policy was up to date, outlining the key principles of the Mental Capacity Act 2005 and how and when to assess capacity. Best interest decision making information was also included as well as information about when and how to apply for authorisation to deprive liberty. The trust's psycho-oncology service was responsible for these processes and were available should staff have any queries.
- Staff received training about patient consent. In the outpatient department all nursing staff and 94% of other staff such as healthcare assistants were up to date with this training. In diagnostic imaging, 75% of nursing staff and all medical staff were up to date.
- Outpatient staff worked on the principles of implied or verbal consent for procedures such as blood taking. For other more complex cancer treatment procedures doctors obtained written consent.

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- Information about mental capacity act, and deprivation of liberty safeguards was displayed around the diagnostic imaging areas.

Are outpatient and diagnostic imaging services caring?

Outstanding



We have rated services as outstanding in the caring domain. This is because:

- Feedback from people using the service and those close to them was continually positive about the way staff treated them.
- We saw staff interacting with patients, recognising their needs and showing motivation to provide care that was kind, considerate and promoted their dignity. Patients thought that staff went the extra mile when providing care for them.
- Patients told us staff listened to them and took time to consider needs and address concerns. They showed a willingness to listen before answering questions honestly.

Compassionate care

- We saw examples of staff taking time to interact with patients and offer support.
- Between October and December 2015 the trust received 22 compliments from patients and visitors which described how staff had treated them with compassion, patience and kindness.
- Patients actively approached us during our inspection, to praise staff and tell us about their experiences. Some patients had been receiving care for several years. One patient told us that staff had worked past their finish time to care for her and escort her to family following an episode of feeling unwell.
- In a patient experience survey undertaken in the magnetic resonance imaging department (2015) patients described staff as having a 'human touch' and treating patients with dignity and respect. This reflected the interactions we saw between staff and patients during the inspection.
- During a listening event we held in the Christie clinic waiting areas we spoke with 88 patients and visitors. During this event patients told us they 'couldn't thank

staff enough', describing them as 'extended family' who were 'very caring', treating them with 'compassion, consideration and respect'. They described the care they received as 'first class' and 'of the highest standard'.

- Patients said radiology staff treated them with dignity and respect, providing 'great care'. We repeatedly heard these positive descriptions and appreciation of caring staff who treated them with dignity and respect. This made them feel cared for and highly valued.
- Radiology aides chaperoned ultrasound examinations and patient confidentiality was observed at all times.

Understanding and involvement of patients and those close to them

- Patients consistently told us staff listened to them before giving good advice. They described doctors taking time to address their concerns whilst considering the needs of their families, providing reassuring discussion without rushing them.
- One patient described staff having a 'willingness to listen' before answering questions honestly, which helped patients and loved ones make difficult decisions. A relative said 'our needs as a family were considered and we were reassured' by staff.
- Staff took time to explain things in a way that patients and loved ones could understand. Some patients had been receiving treatment for a number of years which provided assurance that this type of care was consistent.
- In the patient experience survey undertaken in the magnetic resonance imaging department (2015) patients said they were given clear explanations by staff, and kept informed about what was happening and what to expect during the examination.

Emotional support

- People's emotional and social needs were valued by staff and embedded into care and treatment. For example, patients attending clinic (as well as their loved ones) had access to a specialist team providing complementary therapies like counselling, acupuncture and massage. A 'calm' service helped patients manage feelings of anxiety or panic. We saw staff delivering therapy and noted their positive approach to providing care.
- Clinical nurse specialists were present in clinics, supporting patients with advice and reassurance. They

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described regularly experiencing patients becoming distressed by the nature of their diagnoses, but felt able to dedicate time to these patients offering compassion and support.

- The 'hotline' service enabled patients to ring at any time of the day or night for support with immediate concerns.

Are outpatient and diagnostic imaging services responsive?

Good



We have rated services as good in the responsive domain. This is because:

- Staff were familiar with the local population and individual needs, and care was delivered with this in mind. For example, chaplains from three denominations worked in the hospital, and translation was available for those whose first language was not English.
- Transport, free Wi-Fi and information about wait times were also provided to ensure needs were met. Complementary therapies helped meet the holistic needs of patients and those close to them.
- An information service was available for those in need of extra support at the Information Centre. 80% of the service was provided face to face, with the remainder via email or telephone. We visited the centre which provided hundreds of leaflets about a range of topics including different forms of cancer, treatments, food and nutrition, wig services, and benefits.
- A hotline telephone service was available 24 hours a day, seven days a week to provide advice and support to patients and loved ones.
- The services monitored services based on a range of targets, which were consistently being met. Waiting time, delays and cancellations were minimal and where there were delays senior staff took the time to investigate and manage issues.
- There was a process in place which made it easy for people to complain or raise concerns. Minimal numbers of complaints were received.

Service planning and delivery to meet the needs of local people

- Staff were familiar with the needs of people receiving care or treatment and services were planned and

delivered in line with these. For example, as many patients were from Christian, Muslim or Jewish faiths, chaplains from all these denominations operated in the hospital.

- Speech and language therapy, dietetics, occupational therapy, counselling and complementary services were all available and readily accessible to patients and loved ones free of charge.
- Patient information was displayed on television screens in the main waiting area. The screens displayed news headlines, hospital information (for example complementary therapy details) and estimated wait times. Two televisions had been ordered to provide the same information in department 35.
- Transport was provided for eligible patients via the local patient transport service. For patients still waiting at 5pm, taxi services could be contacted to minimise the time patients were kept waiting. For patients requiring transport but not eligible for transport provision, a telephone was available for them to order a local taxi.
- Noticeboards displayed the names and photographs of nurses on duty each day so that visitors were familiar with those providing care.
- Unisex and disabled toilet facilities were available for visitors in the waiting area. The disabled toilet was wheelchair accessible with hand rails and an alarm pull cord.
- Free Wi-Fi access was available for visitors and we saw the access details displayed in reception areas.
- The waiting area had a café for visitors to purchase hot drinks and snacks. However staff explained that due to staffing issues there were no set opening times. Instead, it opened on an ad hoc basis each day.

Access and flow

- The Department of Health requires outpatient departments to achieve a number of targets. This ensures patients do not wait too long for appointments to review or treat cancer. They state that patients referred to hospital with suspected cancer should receive their first definitive treatment within 62 days of being referred; all patients should have their first definitive treatment following the decision about their treatment within 31 days; and 92% of patients should wait no longer than 18 weeks for their outpatient appointments following referral.

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- Between April 2015 and March 2016, the percentage of patients receiving their first definitive treatment within 62 days of referral ranged from 80% to 90%.
- Between October 2015 and March 2016, 99% of patients received their first definitive treatment following a decision about treatment, within 31 days.
- Between October 2015 and March 2016, 98% of patients received appointments within 18 weeks of referral. The average waiting time for an appointment following referral was 3.5 weeks.
- Other statistics were collated locally to help measure outpatient standards, including rates of follow up to new appointments, number of clinics cancelled and the number of patients who did not attend their appointment.
- Between September 2014 and August 2015 76% of clinics across the trust were follow up appointments. Having too many follow up clinics can impact negatively on access and flow because it limits the capacity for appointments generally. Whilst this was higher than the England average (55%) it was comparable to other cancer hospitals.
- We asked the trust to confirm how many outpatient clinics had been cancelled in the last six months. They did not provide this but instead gave us the current cancellation rate which was 0.03%.
- Between September 2014 and August 2015, the number of patients that did not attend appointments was consistently below (on average 3.5% most months) the England average (6.8%).
- The trust also monitored other indicators such as wait times in clinic, and start and finish times.
- The aim was for 80% of patients to be seen within 20 minutes of their appointment time. Between January and September 2015, 85% of patients sampled were seen within 20 minutes. However, wait times were monitored manually, making it difficult to obtain accurate figures. New IT systems had been ordered which would automatically collate this data with implementation expected in June 2016.
- Patients consistently described having to wait for blood test results prior to appointments. We asked senior staff about this who explained patients were asked to attend one hour prior to their appointment so that blood could be sourced and analysed in time for their appointment. This was necessary in order to gain up to date information about blood tests. Other options such as allowing patients to have blood tests done locally with results sent electronically were not possible due to the difference in care provision and electronic systems across the country.
- In April 2016 the trust began monitoring clinic start and finish times. This showed that 90% of clinics started and ended on time. At 11:15am on one day we noted out of eight clinics, five were running on time, one was one hour behind, another was 40 minutes behind and the last was 20 minutes behind.
- Senior trust managers took steps to try to understand the causes of delays by working for the day in the department. One executive member of staff worked as a healthcare assistant for the day to do this. Managers told us that some delays occurred when patients became unwell in clinic. This had occurred 16 times in the last six months. Treatment and care had to be provided for these patients and available beds had to be found, during which time patients were accommodated in clinic rooms which if in use, could delay a clinic.
- Other delays occurred when patient appointments ran over the allotted time, or when doctors were called away to attend unwell patients or delayed caring for patients in other areas of the hospital prior to clinics starting.
- There was a process in place to escalate delays in clinic. We saw examples where escalation took place following delays.
- Annual leave restrictions were in place to ensure clinics were safely staffed. The requirement was six weeks' notice for specialist clinical nurses and medical staff and four weeks for other staff.
- The department looked at ways to reduce the number of follow up appointments to maintain adequate access and flow. One project involved establishing telephone appointments.
- In diagnostic imaging, figures showed no breaches in six week waits for examinations across all modalities. For example, the maximum wait for MRI appointments was 23 days, outpatient plain film examinations were done on a walk in basis (with the exception of skeletal surveys), positron emission tomography-computed tomography (PET-CT) was four to five days, and bone and cardiac nuclear medicine examinations one to two days.
- Whilst no modalities breached six week targets, wait times for CT examinations were a concern for the trust (on average 34 days). This was noted on the risk register

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and plans were in place to reduce delays through weekend working and shared use of an additional scanner. Longer term plans to purchase an additional scanner were also in place.

- In diagnostic imaging services, porters were based in one department and arranged appointment slots for inpatient scans which in turn ensured flexibility for those requiring scans within appointments. We saw this working well, with no delays in inpatients receiving scans due to transport delays.
- With three imaging departments operating from 9am until 5pm Monday to Friday, magnetic resonance imaging staff worked extended hours to maximise capacity and computed tomography staff offered additional hours between 5pm and 7pm for private patients.
- Diagnostic imaging staff provided on call cover 24 hours a day seven days a week in partnership with another local NHS trust. This was supported by a Christie radiologist consultant who provided secondary cover and out of hours interventional radiology support. All out of hours CT scans were justified by a radiologist.
- For diagnostic imaging appointments, 69% of patients waited no longer than five minutes and a further 17% were seen within five to ten minutes.
- Imaging reports were turned around quickly with the majority reported within five calendar days. For example, 97% of CT outpatient reports and 99.8% of plain film outpatient reports were done within five calendar days in February 2016. For inpatient examinations, 97% of CT, 88% of MRI and 92% of plain film reports were completed within one calendar day in February 2016. This meant that patients received diagnoses quickly and staff could monitor patients in a timely way.

Meeting people's individual needs

- Translation services were available for those whose first language was not English. Leaflets advertising this were visible in reception areas. Translation was done by telephone or face to face. Staff told us family interpretation was avoided to ensure unbiased translation took place. We saw that translation had been arranged for patients attending appointments at the time of our inspection.
- Sign language interpretation was also available if required. Interpreters were booked in one hour slots

which staff told us was not always long enough. They also said they had asked if two hour slots could be booked but were advised there were not enough interpreters to accommodate this.

- The department had a hearing loop for those using hearing aids.
- A hotline telephone service was available 24 hours a day, seven days a week to provide advice and support to patients and loved ones.
- Signs identifying male and female toilets had information displayed in braille for visitors with reduced vision.
- There were initiatives to assist people living with dementia. For example, diversional items such as 'twiddlemuffs' were available for patients to use whilst in hospital take home afterwards. These are knitted blankets with ribbons and buttons, to provide something to hold. There was also a dementia information board in the waiting area which listed key contact numbers, and special flooring which had been laid to help with visual perception.
- Information leaflets were available for patients to take away with them. Patients attending diagnostic imaging appointments were provided with leaflets explaining their examinations and what to expect when they arrived.
- The trust employed a dementia nurse consultant who worked in all areas of the hospital to provide care for patients living with dementia and won awards such as the Queen's Nurse Award 2015 for her work.
- Inpatients waiting for plain film examinations waited in a small area and were not separated by gender. We were concerned this may compromise a patient's dignity and privacy, particularly as we saw patients wearing gowns or nightwear. We discussed this with managers who were already aware of the issue, with a review of the area already included in an annual service plan.
- A patient noticeboard also displayed information for patients about diabetes. Details included the names and photographs of specialist nurses and consultants as well as information about symptoms, leaflets and contact details for support groups.
- The trust had a psycho-oncology service where specialised care could be provided for patients experiencing emotional difficulties or mental health problems. The service was provided by consultants, a counsellor, psychotherapist and specialist nurses.

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- Bariatric equipment such as wheelchairs and walking frames were available if required.
- For patients with complex needs or a learning disability, staff described working closely with carers or family members to provide care or treatment.
- There are no designated areas for paediatric patients to wait, however the number of children in radiology areas was very low, and no children's clinics took place in the main outpatient area.

Learning from complaints and concerns

- Reception areas in diagnostic imaging displayed information for patients about how to make a complaint or provide feedback about services.
- Complaints about diagnostic imaging and outpatient services were rare with only one received about radiology and three received about outpatient services between March 2015 and February 2016. These were about a delay in treatment, lack of information about a procedure, a failure to introduce medical staff to a patient and a failure to send copies of GP letters to a patient. Staff told us that verbal complaints were usually about delays and were dealt with informally at the time they occurred.
- If a complaint could not be resolved at the time, patients or visitors accessed on line complaint forms via the trust website or attended the patient advice and liaison service (PALS) located at the hospital information centre.

Are outpatient and diagnostic imaging services well-led?

Good



We have rated outpatient and diagnostic services as being good in the well led domain. This is because:

- Services had visions and strategies in place to improve services.
- Risk registers were used to monitor risks which fed into service delivery plans. Governance meetings took place regularly.
- Staff liked their managers who had an 'open door' approach. Leaders visited staff to work with them and offer support.

- The service culture placed an emphasis on person centred care, and preventative multi-disciplinary treatment and support. Staff felt privileged to provide care for patients in what they described as a supportive, positive culture.
- Engagement with the public took place, with school visits and senior managers took time to speak to patients in waiting areas and provide care for them. Staff engagement was evident as well, with dedicated sessions provided for staff to share stories and support each other, and initiatives to maintain motivation.
- Innovative clinical trials were a fundamental part of work at The Christie to find new and effective treatments for cancer. Exploration of ideas to improve flow also took place and accreditation schemes formed part of plans for the future.
- There were processes in place to ensure governance issues were identified such as poor attendance in governance meetings or problems reviewing the risk register.

Vision and strategy for this service

- The vision for outpatient services was to provide newer facilities, revise standards and review alternative models for delivering care to improve flow. The department also aspired to opening clinics six days a week, including evenings.
- A diagnostic imaging service delivery plan was in place for the current financial year, encompassing equipment replacement, gaining ISAS accreditation, and the introduction of new clinical posts. This was progressing well, partly due to the charitable funds which allowed a large amount of equipment replacement

Governance, risk management and quality measurement

- A local outpatient risk register held information about a range of risks including uneven floors, needle stick use and trips and falls.
- A diagnostic imaging risk register was also in place. A common theme was increasing capacity issues and aging equipment. The service delivery plan included actions to manage this risk, including the acquisition of an additional MRI scanner, a new interventional suite consisting of two new rooms, and a new CT scanner. Funds for this were generated from charitable sources.
- Divisional governance meetings in diagnostic imaging services had poor attendance as stated in the 1 March

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2016 minutes and stated 112 risks on the risk register had not been reviewed properly. However departmental governance meetings (three times yearly) were well attended and covered a range of topics.

Leadership of service

- Staff told us members of the executive team visited staff regularly during working hours to make themselves visible and check there were no issues. We saw staff talking to executives during our inspection.
- All the staff we spoke to said that managers made themselves available whenever needed as part of an 'open door' approach. For example, the chief executive and matron visited staff during an incident debrief to thank them personally for their action when a patient deteriorated in the outpatient waiting area.
- Radiology managers and directors demonstrated an excellent working relationship with individual modality leads who described them as approachable, taking an interest in day to day aspects of the department.

Culture within the service

- Staff described an open culture where they could raise concerns without fear of reprisal and seek advice from colleagues from other disciplines.
- Specialist clinical nurses working in clinics said the Christie was 'a lovely place to work' and felt proud to be Christie nurses. They described trying to create 'an atmosphere of warmth' for patients who were they said were 'fantastic'. One nurse said she felt 'honoured' to work for the trust.
- Radiographers described a culture of emotional support amongst staff which had been nurtured following shared staff areas with psychology staff.
- Only two staff described a different culture. They felt there was a lack of appreciation from managers and poor communication following a decision to change the way they were managed.

Public engagement

- Staff held open days for members of the public and local schools. For example, in March 2016 the medical physics department invited school children to come and learn about careers in medical physics and the benefits of learning about physics at school.
- Patients attending clinics had the opportunity to join a choir run by the hospital.

- Senior staff described visiting patients as well as staff in outpatient areas. For example, a service manager told us he went to sit with patients in the waiting areas which helped him maintain a patient's perspective.

Staff engagement

- Within the last 18 months, outpatient managers had engaged with staff to obtain their views about the department. Sixty-five percent of staff responded and findings showed an overall engagement score of 90%. Following this, issues highlighted by the review were addressed. For example, reception staff felt less included in the department due to being part of a different management structure. This was changed so staff were managed by the outpatient team. A new outpatient charter was also established to promote fundamental requirements.
- Senior executive managers worked in the department to mix with staff and maintain an understanding of the department.
- Shwartz rounds were held, allowing staff to share inspiring stories. (Shwartz rounds are an evidence-based forum for hospital staff to talk about the emotional and social aspects of caring for patients. The aim is to offer staff a safe environment in which to share stories and offer support to one another).
- Monthly staff support sessions for clinical nurse specialists were in place.
- Internal education and opportunities are also high with some radiography aides currently completing The Christie Care Certificate Programme. Radiographers also had opportunities to rotate around different specialities.
- CT radiographers had a competition each month to aid staff motivation.
- Regular staff meetings took place often scheduled back to back ensuring good attendance. Here staff discussed vacancies, new starters, audit findings, learning from incidents and complaints, clerical and admin issues. There was also opportunity to give two-way feedback for all staff groups.

Innovation, improvement and sustainability

- To ensure sustainability in outpatient services, the trust was exploring the use of telephone clinics and community follow up appointments (in other hospitals and GP practices).

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- In radiology services the introduction of a new Magnetic Resonance (MR) Imaging suite due to open in June 2016 was expected to increase capacity within diagnostic imaging services.
- An interventional nurse led procedure team provided a central line insertion, paracentesis and bone marrow aspiration service.
- The trust had partnered with a third party provider and NHS England to provide education and training for a national PET-CT scanning service network at 30 locations since April 2015. This partnership won national awards including the Public Private Partnership Award at the Laing Buisson's Independent Healthcare Awards 2015 and a Health Investor Award 2015.
- The diagnostic imaging service was working towards gaining ISAS (imaging service accreditation scheme) accreditation this financial year. The department had previously prioritised other aspects of service delivery such as equipment replacement and staff development.

Chemotherapy

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

Information about the service

Chemotherapy services are provided by The Christie NHS Foundation Trust's Systematic Anti-Cancer Therapy (SACT) Service at a range of locations. These include the Christie main site, seven 'outreach' sites, two primary care centres (in Ashton and Bury), and five locations visited by the mobile chemotherapy unit.

Chemotherapy treatment is provided for teenagers and young adults in the custom made Palatine Unit on the main site, under the Haematology, Teenage and young adult and Endocrinology Services directorate.

The adult day case chemotherapy unit is located at the Oak Road Treatment Centre on the main site of the hospital. Patients wait to attend their appointment on the ground floor and treatment is provided on the first floor of the centre in one of 50 treatment spaces. The centre is open from 7:45am until 10pm. The day case chemotherapy unit for teenagers and young adults is located on the ground floor of the Palatine Centre. The unit is open from 8:30am until 4:30pm each weekday and has three chairs and two beds for patients.

Treatment lasts between 30 minutes and eight hours. If treatment lasts longer than eight hours, it is provided on an in-patient basis.

Treatment clinics are also held at 'outreach sites', away from the main hospital at; The Christie at Oldham (at The Royal Oldham Hospital), The Christie at Salford Royal Infirmary, Christie at Wigan (at The Royal Albert and Edward Infirmary) and Christie at Macclesfield (Macclesfield District General Hospital), The Christie at Stockport (at Stepping

Hill Hospital) and The Christie at Leighton (at Leighton Hospital) A mobile chemotherapy unit also operates on one day each week in Rochdale, Trafford, Hyde, Chadderton and Bolton. Here there are spaces for four patients to receive treatment. Some patients also receive chemotherapy treatment at home.

Between April 2015 and March 2016 the treatment centre delivered 43,720 doses of chemotherapy (an average of 120 patients each day). In the outreach sites, 2035 treatments were delivered at the Christie at Oldham, 395 were delivered at The Christie at Salford, 2922 were delivered at the Christie Outreach at Wigan and 2181 were delivered at the Christie Outreach at Macclesfield, 1536 were delivered at The Christie at Stockport and 1596 at The Christie at Leighton. The mobile chemo unit delivered 1781 doses of chemo to patients (an average of five treatments per day). 2272 patients received chemotherapy at home (an average of six treatments per day).

During our inspection we visited the Oak Road Treatment Centre, the Palatine Centre and the mobile chemotherapy unit. We spoke with 26 patients and 35 members of staff including clinical directors, service managers, matrons, staff nurses, senior nurses, clinical specialist nurses, receptionists, and junior doctors. We reviewed six patient records and analysed information provided by the trust before and after our inspection.

Chemotherapy

Summary of findings

We have rated chemotherapy services at The Christie NHS Foundation Trust as outstanding overall. This is because:

- There was an open culture of reporting and learning from incidents. Staff were aware of the Duty of Candour, adopting the principles in everyday practice.
- The areas we inspected were visibly clean and tidy, designated staff undertook cleaning duties and cleanliness and hygiene was reflected in results following audits of particular areas.
- The environments where patients received treatment were light and spacious with age appropriate decoration. Equipment was serviced effectively to ensure it was safe and effective.
- Medicine was stored securely and managed appropriately.
- Staff provided care using national guidance which was reviewed regularly to ensure compliance.
- Local protocols were devised in line with current treatment and clinical trials.
- Pain was managed using core standards and patients described being offered a range of pain relief to manage pain effectively.
- Food and refreshment was available to patients and visitors on units and in restaurants, coffee bars and vending machines
- Chemotherapy services contributed to the trust's reputation as an international leader for research, offering clinical trials to patients on a daily basis.
- People received care from a range of different staff, teams or services which was coordinated and discussed regularly in team meetings. Staff worked collaboratively to understand and meet the range and complexity of people's needs as well as offering advice to other healthcare professionals providing care outside of the trust.
- Staff were able to access the information they required regardless of whether they were on the main site or working remotely. There were fall back plans in place for outreach services to ensure access should internet connectivity be an issue.
- There were clear processes in place for staff to follow when making assessments under the Mental

Capacity Act 2005, undertaking best interest decision making or seeking authorisation to deprive a person of their liberty. Consent processes were also in place and we found evidence that consent was sourced and recorded appropriately.

- Feedback from people using services and those close to them was continually positive about the way staff treated them. People described staff 'going the extra mile'. Some of these patients had years of experience receiving treatment which provided assurance that the way staff treated patients was well established.
- We saw staff treating patients with kindness and good humour, lifting their spirits whilst ensuring they had the information they required when receiving treatment. This demonstrated that relationships between people using the service and those close to them was caring and supportive.
- Patients told us staff listened willingly to them before giving advice and reassurance in a way they could understand. Patients felt they had time to discuss their concerns with staff.
- Information and support services were available not just for patients, but their loved ones as well. This included complimentary therapies such as massage, acupuncture and counselling. A specialist 'calm' service operated for patients experiencing anxiety or feelings of panic.
- Staff were familiar with the needs of local people, catering for a range of religious and therapeutic needs for different patients.
- Individual needs were also catered for and facilities and premises were appropriate for the services being delivered. Children, teenagers and young people were catered for in a purpose built environment with activities and events planned each day to enhance time spent in the department. Play specialists worked with children to help ease their treatment.
- Chemotherapy services were meeting all targets to provide care in a timely way. Whilst some patients described waiting time as an issue, staff took steps to try new initiatives which were proving successful in improving the situation.
- Reasonable adjustments were made to help people who had difficulty accessing services. For example, sign language, hearing loops and language translation were available.

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- Complaints and concerns were managed appropriately and within a suitable time scale. They were taken seriously, recorded and upheld if appropriate following investigation.
- Staff described the vision to expand treatment for patients closer to home.
- The service welcomed visitors from around England as well as internationally, who came to see how outreach services were managed successfully.
- Staff described being supported by managers who operated an 'open door' policy. They actively engaged with staff and patients in decision making where possible. Executive leaders had a visible presence, giving staff briefings in prominent areas of the hospital, and making themselves available at set times for staff to come and talk to them. Patients were invited to forums to help shape new services.
- Staff felt empowered to improve services, raising money to make improvements to the areas they worked for the benefit of patients.

Are chemotherapy services safe?

Good



We have rated chemotherapy services as good in relation to keeping people safe from avoidable harm and abuse. This is because:

- There was an open culture of reporting and learning from incidents. Staff were aware of the Duty of Candour, adopting principles in everyday practice.
- The areas we inspected were visibly clean and tidy, designated staff undertook cleaning duties and cleanliness and hygiene was reflected in results following audits of particular areas.
- The environments where patients received treatment were light and spacious with age appropriate decoration. Equipment was serviced effectively to ensure it was safe and effective.
- Medicine was stored securely and managed appropriately. Fridges storing medicine at low temperatures were fitted with alarms to alert staff if temperature ranges fell outside of normal range.
- Records were available and contained the right details about each patient such as letters detailing assessments, discussions and consent.

Incidents

- There was a culture of reporting and learning from incidents amongst staff. Staff used a web based incident logging system which produced electronic receipts and outcomes. Staff we spoke to knew how to log an incident on the system and gave examples of incidents they had reported.
- Between May 2015 and May 2016 the Oak Road treatment centre reported 131 incidents, all of which were described as minor harm or low harm. The Palatine centre day treatment unit reported only two incidents both of which resulted in no harm to patients. Outreach services reported only two incidents, one of which was no harm and the other which was minor harm.
- In the Oak Road treatment centre, staff graded incidents between one (not serious) and five (serious) which helped determine who should be informed. For

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example, all incidents graded three or above, were discussed at review group meetings. Senior managers reviewed all incidents and discussed them at monthly governance meetings.

- Root cause analysis was undertaken following serious incidents which included recommendations and an associated action plan.
- Staff were aware of the Duty of Candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff described Duty of Candour as part of the culture at the Christie.
- Mortality was reviewed on a monthly basis in governance meetings and meetings led by a medical oncologist.

Cleanliness, infection control and hygiene

- All the areas we inspected were visibly clean, and tidy.
- Domestic staff undertook general cleaning duties including floors, walls, high level surfaces, fridges and legionella control practices such as running taps. Clinical staff disinfected areas using chlorine based substances. On the mobile unit the driver arrived at 7am each morning and cleaned areas prior to nursing staff arriving at 8am.
- Staff were audited for hand hygiene compliance. The trust provided audit results for the Oak Road treatment centre in January, February and April 2016 which showed staff were 100% compliant with good practice.
- Audits of areas were also completed to monitor infection control practice. Issues were highlighted in red to indicate which who was responsible for actioning required improvement. For example, an audit of a kitchen in the Oak Road treatment centre in June 2015 showed 95% compliance with an action for domestic staff to ensure the floor was properly cleaned.
- Staff were also audited for practice relating to the safe handling and disposal of used syringes ('sharps'). The report for June 2015 showed 100% compliance with good practice.
- In a number of areas such as the Palatine centre, we saw taps operated by sensor (non-touch) which helped maintain infection control. Some taps had filters to reduce the presence of Pseudomonas bacterium.

- We reviewed the sluice room on the ground floor of the palatine centre. Inside we found a cleaning cupboard unlocked which gave access to alcohol gel and chloride tablets used for cleaning which should have been locked away securely. We also examined a bin storage room housing cytogenic and clinical waste, which was secured using swipe card entry.

Environment and equipment

- All the areas we visited including the Oak Road treatment centre, the Palatine centre and the mobile chemotherapy unit were all light and spacious with age appropriate pictures on the walls and adequate lighting.
- There was lift access to floors on the main site and the mobile chemotherapy unit should it be required.
- Web based trust IT systems were available at all sites. Away from the main site staff had remote system access which they told us worked well. Staff on the mobile unit also had access to a second internet connection should the primary connection fail.
- Clinical waste bins containing used needles were disposed of when full. On the mobile unit, a designated staff member transported the bin to a suitable clinical waste storage area. This was either at the main hospital or at an NHS hospital in Bolton when the unit parked in the grounds one day each week.
- Resuscitation (including paediatric) equipment was available should a patient deteriorate. This was accessible in each unit and on the mobile unit. Staff told us this equipment was checked daily. Records on the main site confirmed that daily checks were completed. However, as checks of the resuscitation trolley on the mobile unit were returned to the main site each evening, we were unable to review them. Despite this, we reviewed the equipment and saw that it was fully stocked, within expiry date, and sealed. Automatic defibrillators were charged ready for use with pads which within their expiry date.
- We saw records showing that equipment such as infusion pumps and thermometers was serviced to ensure it worked effectively. Out of 96 pieces of equipment, all but one had been serviced in 2015 or 2016.
- In the Oak Road treatment centre, medicines requiring storage at low temperature were stored securely in a fridge in a medicine storage room. Other medicines requiring storage at room temperature were stored here as well.

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- The fridges used temperature monitors which were monitored regularly to ensure the temperature did not fall outside of suitable range. Alarms were activated automatically if temperatures in the fridges rose beyond appropriate range.
- The storage room temperature was also monitored regularly. Room temperatures where medicines are stored should not reach higher than 25° Celsius. We saw records which showed temperatures were higher than they should have been sometimes. For example, the temperature of the storage room recorded on 7 May 2016 was 26.7° Celsius. It was 27.8° Celsius on 10 May and 26.3° Celsius on the 11 May. Staff confirmed that when temperatures reached higher than 27° Celsius, estates were informed. We escalated our concerns to the chief pharmacist. We saw that plans were already in place to mitigate the risks of high room temperatures, with regular assessment and stock rotation. Longer term solutions such as air conditioning were also under review.

Medicines

- Staff used an electronic prescribing system to prescribe all chemotherapy medicines. Medicines were delivered via the Christie pharmacy and an external pharmaceutical company. Deliveries were made each morning at 8am and then hourly throughout the day after that. Deliveries were also made to the outreach sites who recorded these and invoiced the trust.
- A medical courier company delivered and collected medicines to the mobile chemotherapy unit and homes of patients receiving care at home. No medicines were stored on the mobile unit overnight..
- The main site pharmacy was open Monday to Friday between 8am and 5pm to enable patients to collect medicines.
- Staff had access to drugs to treat anaphylaxis (a severe allergic reaction) and hypoglycaemia (low blood sugar) if required.
- Records of treatment prescribed and administered were kept on the hospital electronic prescribing system. Any omitted treatment was also documented here.
- Drug wastage was monitored regularly and discussed at monthly meetings. Any drug wastage accumulated at outreach sites fell under the responsibility of the trust.
- In January 2016 an external review of medicines management use at three Outreach sites was undertaken and confirmed there was significant

assurance that processes were effective. For example, the storage of drugs was secure and in accordance with temperature requirements, drug wastage was adequately recorded and each site had arrangements in place to monitor relevant training.

Records

- Patient records were in electronic and paper format. For example, patient records in the Oak Road treatment centre were in electronic format. Paper records were used on the mobile chemotherapy unit but staff had access to the electronic records as well. In outreach treatment units based at other hospitals, staff entered details onto the patient record system used by the hospital and then sent the information across to staff at The Christie who duplicated the details on the Christie electronic patient record system.
- We saw that records included important information relating to patients such as weight, treatment regime, psychological assessment information and co-morbidities. Fields on the electronic system were mandatory to ensure important information about each patient was recorded. Dependent upon the information recorded, the system prompted staff to refer patients to other services such as dieticians or medical teams if required.
- Records were prepared the day before clinic and delivered to the unit, if notes were not available, staff accessed the electronic system to source information.
- We reviewed six patient records during our inspection. These were legible and contained information about clinical assessments and patient circumstances, discussions, letters to other healthcare providers and consent.

Safeguarding

- Safeguarding training was mandatory. Staff completed different levels of training based on their level of contact with patients.
- Figures showed that 93% of staff in chemotherapy services were compliant with level two safeguarding training against a target of 95%. Figures for staff in the teenage and young adult service showed that 96% of staff were up to date.
- A lead safeguarding representative was available for staff to contact with concerns or queries.
- Safeguarding information was displayed including processes and contact details for raising concerns.

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- Nurses described feeling supported by the lead safeguarding nurse. However staff also said they relied heavily on the lead, and were not always aware of cover arrangements during periods of absence.
- Staff on the mobile unit told us they made contact with specialist nurses to share safeguarding concerns and check whether issues had already been reported.

Mandatory training

- Two practice educators worked on the Palatine Unit and one worked in the Oak Road treatment centre to help ensure staff completed the right training.
- Mandatory training covered topics including basic life support, equality and diversity, information governance, moving and handling and fire safety.
- Ninety-one percent of staff in chemotherapy services were compliant with mandatory training overall against a target of 95%. When broken down into topics, we saw that 100% of nursing staff were compliant with training in root cause analysis, risk management, moving & handling and emergency planning training. However there were some topics where staff compliance fell below the trust target. For example, only 81% of nursing staff were compliant with 'hospital essential life support' training. 78% of staff were compliant with information governance training and 85% of staff were trained in medicines management training. We were not provide with figures for medical staff.
- The trust provided figures for the Palatine Centre staff who cared for young people, teenagers and young adults. However figures did not differentiate between day treatment staff and ward staff. Overall, staff were compliant with mandatory training which fell below the target of 95%. Of concern were medical staff compliance for topics including mental capacity act 89%, and fire safety awareness (78%). For nurses, only 68% were compliant with 'hospital essential life support' training.
- The trust confirmed they were aware that training was not meeting the overall compliance target of 95%. To try to improve this the issue was planned for discussion at performance meetings and placed on the risk and quality governance committee agenda as well.

Assessing and responding to patient risk

- Processes were in place to manage risks to patients such as deterioration. For example, resuscitation trolleys were available with easy access to ensure they could be accessed quickly, and oxygen was readily available should it be required.
- The trust operated a "baton bleep" system for senior medical staff to provide support such as urgent incidental findings or emergency care. The system operated from Monday to Friday between 9am and 5pm. Outside of these times a standard call could be made to a medical doctor on call via the trust switchboard.
- Although some home treatments were available, these were carefully assessed as appropriate for homes to lower the risks to patients receiving care away from the main hospital.
- Checks were in place to help ensure mistakes did not occur when treatment was being provided. For example, blood results were checked by one nurse during preparation and a second nurse on the day of treatment.
- In the Oak Road treatment centre day unit, placemats in each treatment area contained information reminding patients to inform staff of potential fall risks such as mobility issues. This helped staff provide extra support when required to lessen the risk of falls.
- Plans were in place to ensure treatment on the mobile unit could continue if issues arose such as vehicle break down. Staff told us that this had occurred once, and that an area of the treatment unit at the Oak Road treatment centre was made available for these patients instead. Further plans were in place should evacuation be required. On the mobile unit staff had 'evacuation' packs with necessary equipment which were checked daily.
- The Acute Oncology Management Service operated a hotline for patients or healthcare professionals from other district general hospitals to make contact 24 hours a day seven days a week should patients need advice or assistance urgently. In April 2016 1681 calls were received, resulting in 479 patients being admitted to the Christie and 226 patients being admitted to other district general hospitals (128 of which were deemed to be medical emergencies).

Nursing staffing

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- Chemotherapy was nurse led both at the main site and outreach sites including the mobile unit. Nursing staff worked in one of six 'disease groups' such as the 'head and neck' or 'outreach' group for a six month period before rotating to another group.
- On the mobile unit one senior nurse and one staff nurse worked together to care for patients.
- In April 2016 the chemotherapy services division had one nursing vacancy, five staff on maternity leave and three absent through long term sickness. Two staff members were due to start employment. By May 2016, four nurses and two healthcare assistants had been recruited. The scheduling team had one vacancy with a new member of staff due to commence employment in June 2016.
- Planned establishment was not calculated using an acuity tool due to difficulty sourcing one. Instead, an electronic scheduling system helped staff plan appropriate staffing levels based on treatment regime requirements and capacity in the unit. For example, for patients receiving bolus treatment, one to one nursing was planned. For patients receiving treatment lasting between one and ten hours, one to one staffing was planned for the start and then one to five nurse to patient ratios were planned for the rest of the treatment.
- In the meantime, senior staff were developing their own tool for use within the service and outreach areas.
- Sickness rates were monitored. Between April 2015 and March 2016 the sickness rate for nurses in chemotherapy services was 2.5%, and was 2.7% for nurses in the Palatine centre; below the average NHS sickness rate (4.4% February 2016).

Medical staffing

- Two clinical fellows worked in the Oak Road treatment centre each day between 8am and 6pm. After 6pm the unit had access to on-call medical staff. Consultants did not work on the unit.
- No medical staff worked on the mobile units. However medical advice was available via the 'baton bleep' should it be required.

Major incident awareness and training

- The hospital was not a receiving hospital for major incidents. Should an incident occur nearby, managers explained that emergency services would need to admit to the nearest receiving hospital.

- Despite this on call managers in the trust did receive emergency preparedness training.

Are chemotherapy services effective?

Good



We have rated chemotherapy services as good for providing care that is effective. This is because:

- Staff provided care using national guidance which was reviewed regularly to ensure compliance.
- Local protocols were devised in line with current treatment and a vast range of ongoing clinical trials.
- Pain was managed using core standards and patients described being offered a range of pain relief to manage pain effectively.
- Food and refreshment was available for patients and visitors on units and in restaurants, coffee bars and from vending machines.
- Chemotherapy services took part in research and contributed to the trust's reputation as an international leader for research, offering clinical trials to patients on a daily basis.
- People received care from a range of different staff, teams or services which was coordinated and discussed regularly in team meetings. Staff worked collaboratively to understand and meet the range and complexity of people's needs as well as offering advice to other healthcare professionals providing care outside of the trust.
- Staff were able to access the information they required regardless of whether they were on the main site or working remotely. There were fall back plans in place for secondary internet access to ensure staff had constant internet connectivity.
- There were clear processes in place for staff to follow when assessing patients under the Mental Capacity Act 2005, making best interest decisions or seeking authorisation to deprive a person of their liberty. Consent processes were also in place and we saw evidence that consent was sourced and recorded appropriately.

However:

- Review dates for treatment protocols appeared to be out of date

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Evidence-based care and treatment

- Staff provided care based on national guidance formulated by the National Institute of Health and Care Excellence (NICE) such as guidance for giving electrically-stimulated intravesical chemotherapy for superficial bladder cancer (IPG277).
- Records showed guidelines were reviewed by the trust's clinical research and effectiveness committee to ensure practice remained in line with guidance. The latest review took place in March 2016. Out of 152 guidelines used by the trust, practice was found to be compliant with 149.
- This guidance and any clinical trial or research requirements were incorporated into locally devised protocols. They outlined key tasks such as how many times patients required assessment and what tests to undertake to monitor patients. Any deviation from protocols was done by medical staff. Senior managers told us that protocols were reviewed annually with master copies held in offices. We checked a sample of these and found that some were out of date. For example, the upper gastrointestinal treatment protocol was dated 2012 and the protocol for administering Docetaxel to urology patients was due for review in 2015. On the mobile chemotherapy unit, the guideline for managing cytotoxic spillage review date was 2008. We checked the protocols electronically but found the same issue with review dates. Staff assured us that the protocols were regularly reviewed as research findings were published to see whether treatment regimens required adjustment. However, our findings left us only partially assured that reviews took place in a timely way.
- Staff did not routinely undertake audits to ensure staff were compliant with practice such as record keeping. Instead, system tools (such as mandatory fields on all electronic records) were in place which prompted staff to adopt the correct practice.

Pain relief

- Three and a half whole time equivalent staff worked in a pain management team. This included one consultant and clinical nurse specialists.
- The team had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015) and adopted a number of the recommendations made regarding standards in specialised services. These

included having dedicated pharmacy input, input from other specialists (such as the SCT), engagement with audit, timely access to pain relief and a pain assessment tool.

- Patients told us that staff explored a range of medicines to treat their pain in order to find the most effective.

Nutrition and hydration

- Soup and sandwiches were provided for patients undergoing chemotherapy at the main site.
- For patients attending the mobile unit, tea coffee and biscuits were provided. Some staff brought in extra treats for patients such as cakes.
- Additionally, the main site had a dining room selling snacks, salads or hot meal between 7:15am and 7pm on weekdays and between 9:30am and 4pm at the weekend. There was also a tea bar open Monday to Thursday 9am until 5pm and Friday from 9:30am until 5pm. However we noted there were occasions when volunteer staffing problems meant opening times were not guaranteed.

Patient outcomes

- The hospital was known as an international leader for research and there were a number of clinical trials and research ongoing at the time of our inspection. 13% of patients were involved in clinical trials which was higher than the national average of 5%.
- Each disease group was involved in clinical research. For example, the lymphoma team research helped identify that following chemotherapy; positron emission tomography scanning could identify certain patients (suffering with early stage Hodgkin Lymphoma) who did not require radiotherapy. This helped reduce patient exposure to radiation and the length and cost of treatment which overall helped improve patient wellbeing.
- A report published by Public Health England and Cancer Research UK in August 2016 looked at 30-day mortality following systemic anticancer therapy (SACT) in 2014 for both breast and lung cancers. The Christie was not an outlier for either palliative or curative intent for both cancer sites.
- Deaths within 30 days of systematic anti-cancer treatment were included in an annual audit for all non-surgical disease groups. The latest report for deaths between April 2014 and March 2015, showed that the number of deaths had reduced. Findings were that 61%

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of deaths were caused by progressive disease, 0.4% of deaths were treatment related, and 35% of cases were due to neutropenic sepsis which was a reduction on the previous year (46%). Recommendations were made for each disease group to improve care and treatment such as considering palliative care early in treatment, undertaking social assessments and mental capacity in elderly patients and closer working with GP surgeries if following the death of a patient.

- Patients were individually assessed and discussed for clinical trial suitability at multi-disciplinary team meetings.
- Additionally, staff completed local audits to measure the effectiveness of services and explore ways to improve. For example an audit of the appointment system found that only 55% of patients were given their next appointment prior to leaving, against a target of 90%. Staff were looking at ways to improve this at the time of our inspection. Another audit identified delays for patients waiting for prescriptions. The audit showed that some prescriptions were not written in a timely way and changes were made to ensure staff reminders were sent four days prior to a patient appointment to help reduce delays.

Competent staff

- Nurses rotated around disease groups to ensure competencies were maintained.
- Staff received system training during induction. Nurses told us they worked on a supernumerary basis for approximately six weeks but that they only joined teams as substantive members when they felt ready.
- Staff competencies were recorded in training books. Competencies included administering individual treatments and providing information about certain regimens to new patients.
- Staff received annual appraisals to review work, set targets and provide support. Between April 2014 and March 2015 100% of administrative, clerical, estates and ancillary staff (for example housekeepers), 94% of nursing staff and 93% of additional clinical services (such as healthcare assistants) in chemotherapy services, received their appraisal last year against a target of 95%.

- Nurses told us they had opportunities to develop. They had access to university courses to aid development through a staff education programme. We saw nurses that had been able to undertake these as well in house training in areas such as chemotherapy.
- Revalidation for nurses was monitored by the trust. Managers received monthly reports about their staff who were due to revalidate in the upcoming 3 months. Staff training was provided to introduce the topic of revalidation and help inform nurses about requirements. We saw that in July 2016, 210 nursing staff attended training. An external review of the trust's preparedness for nurse revalidation was completed in March 2016 and found high assurance that the trust acknowledged and understood its role in the process of revalidation.

Multidisciplinary working

- Internal multi-disciplinary clinical team meetings took place weekly in the Palatine centre. They were attended by staff from a range of disciplines including specialist clinical nurses, allied health professionals, physiotherapists, social workers, ward managers and consultants in oncology, haematology and paediatrics. We observed one meeting and saw that patients were individually discussed with contributions from staff of all disciplines. We saw that the group made telephone contact with a patient's local care provider during the meeting to discuss potential treatment and expected outcome. The call was placed on loud speakers to enable everyone present to contribute.
- Monthly Systematic Anti-Cancer Treatment delivery group meetings took place monthly. These were attended by staff from areas such as research, outreach, clinical oncology, medical oncology, clinical audit, chemotherapy, haematology and finance managers. Here a range of topics relating to pharmacy, mortality, action plans, clinical trials and drug wastage were discussed.
- Some specialists worked with colleagues at other sites to provide care. For example, head and neck clinicians provided care for patients in a neighbouring trust.
- Pathology services were provided in partnership with private sector company. The venture was put into place in 2014. Histopathology (diagnosing tumours) and blood sciences such as haematology, stem cell processing and blood transfusion were provided.

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- Surgical and oncology staff worked together to provide support for patients with gynaecological cancers.
- Chemotherapy services worked closely with local district nurses to ensure patients had support at home and with staff in the complimentary therapy department who provided calming techniques for patients with needle phobias.
- Representatives from the charity 'CLIC Sargent' (a charity providing emotional, practical and financial support for children and families affected by cancer) worked with staff to enhance care for children being treated at the Palatine centre. For example, helping locate accommodation close by to hospital for families of children undergoing treatment.

Seven-day services

- At the time of our inspection outpatient clinics operated from Monday to Friday between 8am and 10pm. On Saturdays between 8am and 6pm, new patients were invited to visit the Oak Road treatment centre when it was less busy. Senior managers told us that clinics could be operated on Saturdays if there were capacity issues.
- The mobile unit operated Monday to Friday between 8:30am and 4:30pm.

Access to information

- Clinical nurse specialists told us they felt able to approach colleagues in other departments to ask for information or seek advice about patients.
- Staff accessed patient details via paper patient records or from the trust's electronic patient system.
- Staff responsible for scheduling patient appointments and getting things ready for patients prior to their arrival accessed information on electronic systems. However senior managers described issues with the systems. For example, they told us that the scheduling system did not have any links with the trust appointment systems. Staff set up a group to address the issues and were in the process of inviting companies to come and present new ideas for improvement.
- Staff on the mobile unit had access to a 'communications' folder where important information was documented and shared by senior nurses.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to access an up to date trust policy about assessing mental capacity as well as the process

for seeking authorisation to deprive a person of their liberty. The policy was up to date, outlining the key principles of the Mental Capacity Act 2005 and how and when to assess capacity. Best interest decision making was also included as well as information about when and how to apply for authorisation to deprive liberty. The trust's psycho-oncology service was responsible for these processes and were available should staff have any queries.

- Staff received training in consent and figures showed that 94% of staff were up to date.
- If consent was required, documents were kept in patient records and reviewed during appointments. In the Oak Road treatment centre, consent was obtained during a third appointment to help ensure patients had time to fully consider their treatment. (In the first appointment the treatment was explained and in the second appointment discussion took place with time for patients to ask any questions they may have). If notes were not available, consent was completed again.
- Nurses checked consent when preparing to give patients chemotherapy treatment.
- In the records we reviewed, consent forms were completed appropriately and were relevant to particular procedures such as intrathecal chemotherapy or line insertion.

Are chemotherapy services caring?

Outstanding



We have rated chemotherapy services as outstanding in the caring domain. This is because:

- Feedback from people using the service and those close to them was continually positive about the way staff treated them. People described staff 'going the extra mile'. Some patients had years of experience receiving treatment which assured us that the way staff treated patients was well established.
- Findings from patient experience surveys undertaken by the trust supported what patients told us about their care and reflected the positive interactions that we saw between staff and patients during our inspection.
- We saw staff treat patients with kindness and good humour, lifting their spirits whilst ensuring they had the

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information they required when receiving treatment. This demonstrated that relationships between people using the service and those close to them was caring and supportive.

- Patients told us staff listened willingly before giving advice and reassurance in a way they could understand. Patients felt they had time to discuss their concerns. This was reflected in patient surveys undertaken by the trust.

Compassionate care

- Patients actively approached us during our inspection, to praise staff and tell us about their experiences. Some patients had been receiving care for several years.
- Patients spoke highly of the staff. They told us they 'couldn't thank staff enough', describing them as 'extended family' who 'were very caring', treating them with 'compassion, consideration and respect by going the extra mile'.
- We saw staff helping patients and talking to them while providing treatment. They were friendly and jovial, explained their actions and included relatives in conversations.
- Some patients said they could not fault the service. Whilst some had to wait a long time when receiving treatment they still described the care provided overall as 'marvellous' and 'very, very good'.
- In patient experience surveys undertaken by the trust, 100% of patients reported staff being friendly and sensitive and treated with respect and dignity by staff in the department.
- Patients were seated in particular areas of the Oak Road treatment centre to help preserve their dignity when required. For example, patients with breast cancer were seated at the end of the unit. All patients surveyed about this element of their care at the Oak Road Treatment Centre said they felt their needs were met in relation to privacy and dignity.

Understanding and involvement of patients and those close to them

- Patients told us staff listened to them before giving good advice. They described doctors taking time to address concerns whilst considering the needs of families, providing reassuring discussion without rushing them. One patient described staff having a 'willingness to listen' before answering questions honestly, which helped patients and loved ones make difficult decisions.

- In patient experience surveys undertaken by the trust, 95% of patients at the Oak Road Treatment Centre said that when they asked questions, staff explained the answers to them in a way they could understand. Ninety-six percent of patients reported that staff explained what they were doing when administering treatment.
- Staff explained things in a way that patients and loved ones could understand, taking time to explain things clearly. This meant they felt fully informed about their care and treatment. Some patients had been receiving treatment for a number of years and told us this type of care was consistent.
- Patients taking part in trials told us everything relating to their care and treatment was explained to them.

Emotional support

- Relatives of children receiving treatment in the Palatine centre told us that they felt staff looked after them as well, and that nothing was too much trouble, which made them feel very reassured. One patient we spoke described feeling positive about the future and told us there was 'no doubt that the Christie [had] played an 'outstanding role' in bringing them to that point.
- Clinical nurse specialists were present in clinics, supporting patients with advice and reassurance. They worked in every specialty, providing a service for patients attending appointments. Staff explained that they regularly cared for patients feeling distressed by the nature of their diagnoses, and dedicated time to offer compassion and support.
- Every Saturday, patients beginning treatment were invited to visit the Oak Road treatment centre to familiarise themselves during quieter times.

Are chemotherapy services responsive?

Good



Following our inspection, we have rated chemotherapy services as good in relation to being responsive to patients' needs. This is because:

- Staff were familiar with the needs of local people, catering for a range of religious and therapeutic needs. Individual needs were also catered for and facilities and premises were appropriate for the services being

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delivered. Children, teenagers and young people were catered for in a purpose built environment with constant activities and events planned each day to enhance time spent in the department. Play specialists worked with younger children to help ease treatment.

- Outreach services were in place across the north-west region, which ensured patients could receive treatment closer to home. Where treatment requirements allowed, patients could also receive treatment at home rather than attending a treatment centre.
- Information and support services were available not just for patients, but loved ones as well. These included complimentary therapies such as massage, acupuncture and counselling. A specialist 'calm' service operated for patients experiencing anxiety or feelings of panic.
- Reasonable adjustments were made to help people who have difficulty accessing services. For example, sign language, hearing loops and language translation were available for patients if required.
- Chemotherapy services were meeting all targets relating to providing care in a timely way. Whilst some patients described waiting time as an issue, staff took steps to try new initiatives which were proving successful in improving the situation.
- Despite describing delays between arrival in clinic and the delivery of chemotherapy treatment, patients told us the care was 'excellent'. Staff explained that delays were usually unavoidable given that blood analysis was often required prior to appointments for chemotherapy. Staff met regularly with patients to ensure they were aware of the reasons for delays and discussing ways to improve.
- Complaints and concerns were managed appropriately and within a suitable time scale. They were taken seriously, recorded and upheld if appropriate following investigation.

Service planning and delivery to meet the needs of local people

- Staff were familiar with the needs of people receiving care or treatment and services were planned and delivered in line with these. For example, as many patients were from Christian, Muslim or Jewish faiths, chaplains from all these denominations operated in the hospital.

- Speech and language therapy, dietetics, occupational therapy, counselling and complementary services were all provided free of charge not only for patients but for those close to them as well.
- Children and young adults over 16 years of age were catered for by the teenage and young adult (TYA) service. Here they had access to the purpose built Palatine Centre. The centre hosted two play rooms for children downstairs, and a larger room for young people upstairs. Television, music and activities such as pizza night and musical instrument tuition were available ensuring patients had access to a range of activities.
- Outreach services were provided throughout the north-west region to ensure patients could receive treatment closer to home. The trust had worked to ensure that 80% of treatments were available to patients within a 20 minute drive. Locations included, Wigan, Oldham, Macclesfield, Leighton, Bolton, Hyde, Chadderton, Salford, Rochdale and Trafford.
- Patients and visitors had access to free Wi-Fi throughout the main site.
- There were vending machines throughout the hospital containing drinks and snacks for people who wished to purchase them.
- Patients told us that waiting times were not displayed which added to what was already a stressful time.

Access and flow

- The Department of Health requires outpatient departments to achieve a number of targets. This ensures patients do not wait too long for appointments to review or treat cancer. They state that patients referred to hospital with suspected cancer should receive their first definitive treatment within 62 days of being referred (minimum 85% of patients or 90% if patients have been referred from a national cancer screening programme); and that patients should have their first definitive treatment following the decision about their treatment within 31 days (minimum 96%). Chemotherapy services were regularly meeting these targets.
- Between October 2015 and March 2016, an average of 96% of patients received their first definitive treatment within 62 days of receipt of referral. 100% of patients referred through national screening programmes received their first definitive treatment within 62 days.

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- Between October 2015 and March 2016, 100% of patients received their first definitive treatment following a decision about treatment, within 31 days.
- We asked the trust to confirm how many outpatient clinics had been cancelled in the last six months. They did not provide this but instead gave us the current cancellation rate which was 0.03%.
- Local targets were also in place to help keep waiting times to a minimum. These included the aim for a maximum waiting time of 20 minutes and that 85% of patients having one day treatments should be treated within one hour arrival in the chemo chair. Figures for last year (April 2015 to March 2016) showed that on average, the Oak Road treatment centre met this target with 85.5% of patients receiving treatment within one hour. Only 1% of patients waited longer than three hours.
- Staff had worked to improve waiting times for patients over the last three years. One initiative was to provide blood analysis and treatment over two days rather than asking patients to wait for blood analysis and receive treatment all on the same day. The introduction of this initiative resulted in over 90% of patients receiving treatment within the hour between April 2014 and March 2015 and a rise in the overall percentage of patients receiving treatment rise from 73% in April 2013, to 87% in March 2015.
- Patients were scheduled for treatment by a dedicated team of staff using an electronic system.
- Patients attending the chemotherapy day unit under the 'one day' treatment schedule usually underwent blood tests prior to being seen by a doctor or nurse. As a result of this requirement, patients were asked to attend one hour prior to their appointment time, to allow for blood analysis. This was because the results of the blood test would determine whether patients were well enough to receive treatment. At times this created delays which patients told us were frequent. Senior managers explained that blood tests had to be taken in this way because other methods were not available. For example, patients were not able to have blood tests taken in their local area prior to their appointment because different areas of the country used different systems for recording blood results. Not all of these were linked with the hospital. It was also important to obtain blood results close to treatment time to ensure the results were up to date.
- Patients described delays as 'frustrating' with little information provided when clinics were running late. One patient who had been attending regularly since November 2015, said the longest wait was three hours. However, they also told us that given the number of patients, waits were 'quite understandable' and that 'even when it is busy, staff listen and respond as needed'.
- We saw that risks to patient care due to inconsistent agreements with local trusts to access blood results was included on the risk register.

Meeting people's individual needs

- Translation services were available for those whose first language was not English. Leaflets advertising this were visible in reception areas. Translation was done by telephone or face to face. Staff told us family interpretation was avoided to ensure unbiased translation took place. We saw that translation had been arranged for patients attending appointments at the time of our inspection.
- Sign language interpretation was also available. Interpreters were booked in one hour slots which staff told us was not always long enough. They also said they had asked if two hour slots could be booked but were advised there were not enough interpreters to accommodate this.
- The department had a hearing loop for those using hearing aids.
- The trust had a psycho-oncology service where specialised care was provided for patients experiencing emotional difficulties or mental health problems. The service was provided by consultants, a counsellor, psychotherapist and specialist nurses.
- The trust employed a dementia nurse consultant who worked in all areas of the hospital to provide care for patients living with dementia and won awards such as the Queen's Nurse Award 2015 for her work.
- An information service was available for those in need of extra support. 80% of the service was provided face to face, with the remainder via email or telephone. We visited the information centre which provided hundreds of leaflets about a range of topics including different forms of cancer, treatments, food and nutrition, wig services, and benefits. Patients were positive about the information provided to them.

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- The 'hotline' service enabled patients to ring at any time for support with immediate concerns. We heard staff giving advice to the parent of a child receiving treatment which was informative and delivered with a polite manner.
- People's emotional and social needs were valued by staff and embedded into care and treatment. For example, patients attending clinic (as well as their loved ones) had access to a specialist team providing complementary therapies like counselling, acupuncture and massage. A 'calm' service was also provided to help patients displaying feelings of anxiety or panic. We saw therapy taking place and noted the positive approach staff took when providing care.
- Staff told us that patients with learning disabilities or complex needs were usually seated close by to nurses' stations. They told us that the majority came with carers who could help staff identify patient needs.
- Staff described their vision to expand treatment for patients closer to home, with challenging and innovative objectives which were being achieved over time
- The service welcomed visitors from around the world, to come and see how outreach services were managed successfully and took a systematic approach to work with other organisations in order to improve care for patients closer to home
- Staff roles were structured, with management and clinical leads overseeing the service. Regular meetings involving service leads and a range of staff such as consultants, research leads, nurses and pharmacy took place to ensure governance, risk management and quality measurement was in place and reviewed regularly. The risk register covered the risks that managers told us about during our visit. The Christie quality mark had helped ensure consistent standards were maintained across all the treatment centres operating in the region.
- Staff described being supported by managers who operated an 'open door' policy, actively engaging with and involving staff and patients in decision making. Executive leaders had a visible presence, giving briefings and making themselves available at set times for staff to come and talk to them. Patients were invited to forums to help shape new services.
- Managers and leaders motivated staff to succeed. Staff told us they felt empowered to improve services, raising money to make improvements to areas for the benefit of patients.

Learning from complaints and concerns

- Reception areas displayed information for patients about how to make a complaint or provide feedback about services.
- If a complaint could not be resolved at the time, patients or visitors accessed on line complaint forms via the trust website or attended the patient advice and liaison service (PALS) located at the hospital information centre. In the Oak Road treatment centre, placemats were used on tables next to treatment chairs which provided patients with information about the Patient Advice and Liaison Service (PALS) should they have unresolved concerns.
- Complaints about chemotherapy services were rare with only five received about the Oak Road treatment centre between March 2015 and February 2016. These were about communication, attitude of a staff member and the care of a patient.
- Feedback from complaints and compliments was shared in quarterly newsletters which were displayed on noticeboards.

Are chemotherapy services well-led?

Outstanding



We have rated services as outstanding in the well led domain. This is because:

Vision and strategy for this service

- The Systematic Anti-Cancer Therapy (SACT) Service had a five year strategy in place from 2015-2020. The previous five year strategy had been to ensure that 80% of treatments were available to patients within a 20 minute drive and this target had been reached. This latest strategy focused on delivering treatment for solid tumours in the most clinically appropriate place, with a single governance arrangement across the region, to improve access to clinical trials and improve patients' experience. One of the indicators for this was to increase the number of outreach treatments available to patients.
- Following the success of outreach and home based treatment services, staff described their vision which

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corresponded with the indicators on the five year strategy. Particularly, staff described wanting to expand outreach teams in order to provide more cancer treatments for patients closer to home.

Governance, risk management and quality measurement

- The systematic anti-cancer therapy service was led by a head of service and a clinical lead to ensure chemotherapy treatment was delivered to patients across the north-west area. A lead nurse also supported the process by working to ensure staffing was adequate, national cancer measures were implemented, incidents were reviewed and participation in audit took place.
- Monthly meetings were held by a service delivery group chaired by the head of service or the clinical lead. Here, a multi-professional group (including consultants, trial managers, research nurses and pharmacy representatives) discussed topics such as policies, newly funded treatments, incidents, mortality rates, drug wastage and patient experience. This provided an opportunity for regular discussion to aid improvement of services.
- A risk register was in place including a description of the risk, staff responsible for managing the risk, the likelihood and consequence of the risk occurring and actions to mitigate it. The items listed corresponded with what managers told us were their main concerns. For example, nurses working remotely without medical support, with actions to mitigate the risk including extra personal safety training and guidance for lone workers.
- Other governance measures electronic prescribing which helped reduce errors in interpreting written prescriptions and speed up processes. Chemotherapy incidents were reviewed monthly by the trust's Safe Medicines Practice Committee. In-house treatment protocols for staff delivering treatment to follow were also in place within each disease group. This provided clinical staff with clear instructions for delivering multiple treatment regimens for patients. Treatment provided outside of protocol was permitted but monitored by the delivery group. We were told the protocols were reviewed yearly or following updates. However we found that some protocol reviews appeared out of date when we reviewed paper and internet versions during our inspection.
- With the increase of outreach services highlighted in the five year strategy, quality was seen as paramount. To

ensure standards did not fall, the Christie Quality Mark was introduced in 2014. With representatives from governance, nurses, governors, consultants and managers from the Christie and other trusts locally formed a working group to ensure consistency in standards was maintained.

Leadership of service

- Numerous staff told us they felt supported by their managers.
- Executive staff operated an 'open door policy' and staff told us they were approachable and responsive to any issues raised. They made themselves available for staff on a regular basis through initiatives such as drop in sessions, walk rounds and briefings.
- Part of the lead nurse role involved working with staff clinically. This requirement was listed in the delivery group policy and helped ensure the lead nurse maintained an awareness of any issues affecting the delivery of services day to day, as well as maintain a good working relationship with other clinical staff working in the department day to day.

Culture within the service

- Staff described an open culture with 'cohesive' teams, where staff could raise concerns without fear of reprisal and seek advice from colleagues from other disciplines. They told us they felt heard and received responses from senior staff.
- Specialist clinical nurses working in clinics said the Christie was 'a lovely place to work' and felt proud to be Christie nurses. They described trying to create 'an atmosphere of warmth' for patients who were they said were 'fantastic'. Nurses told us they felt 'honoured' to work for the trust.
- Healthcare professionals told us they 'wouldn't work anywhere else'. Other staff said they had made a conscious decision to come to work here, rather than other hospitals.
- Domestic staff felt included in clinical teams which made them feel they were 'looked after'.
- Nurses on the chemotherapy day unit described working with colleagues to raise money for the unit which enabled them to add 'extra touches'.
- Medical staff told us they loved working for the trust. Some came from abroad, after waiting considerable lengths of time to source posts (one consultant waited for two years to obtain a position in the trust).

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- Duty of Candour was incorporated into the ethos of the organisation where staff demonstrated an open and honest approach to work.

Public engagement

- The Oak Road treatment centre asked patients whether they would recommend services to friends and family. Between October 2015 and March 2015 1441 patients provided feedback, with 99% of patients providing a positive response (agreed or strongly agreed).
- Patients attending clinics had the opportunity to join a choir run by the hospital.
- The service ran patient focus groups on a quarterly basis to identify positive and negative aspects of the service. So far themes included issues with car parking, wait times and access to new appointments. This also gave staff an opportunity to explain the reasons for some issues which increased understanding.
- When building the Oak Road treatment centre staff worked with patients to source preferences. These were then incorporated into the new build. For example, although side rooms were available, patients wanted to sit together and the layout was designed with this in mind.
- Staff invited a local graffiti artist to come and work with children to help design the artwork around the palatine centre.

Staff engagement







- Schwartz rounds were held, allowing staff to share inspiring stories. (Schwartz rounds are an evidence-based forum for hospital staff to talk about the emotional and social aspects of caring for patients. The aim is to offer staff a safe environment in which to share stories and offer support to one another).

- Monthly staff support sessions were in place for clinical nurse specialists to attend.
- Team briefings were held monthly by the chief executive. Drop in sessions were also organised at various times on 16 dates between January and May 2016. Staff were invited to attend these should they wish.
- Social events were held to engage with staff. For example, a quiz night took place to help inform staff about our inspection.
- Quarterly newsletters were published which provided staff with information about a range of topics including, clinical updates and service changes.

Innovation, improvement and sustainability

- The operational delivery group and service leads used an operational policy which described ensuring the implementation and sustainability of guidance to improving outcomes, working to guidance and improving the service. They met regularly, covering a range of topics to help ensure these requirements were met.
- The service welcomed visitors from the UK and abroad to come and learn about innovations within the service such as the mobile chemotherapy and the delivery of chemotherapy at home. Recent visits from a group of nurses in China, and another UK hospital trust had recently taken place.
- Treatment at home was revolutionising care for cancer patients. At the time of our inspection, patients in ten areas of the North West were being offered treatment at home.

Radiotherapy

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

Information about the service

The trust is one of the largest cancer centres in Europe and serves a population of 3.2 million people. It is based at three sites, the main site is at the Christie hospital at Withington in Manchester and there are two satellite sites - Christie@Oldham and Christie@Salford, both of these are housed in purpose built accommodation. The Christie site has eight linear accelerators that deliver radiotherapy treatment and the other sites have two linear accelerators each. In 2014/15 the Christie site delivered 67,047 fractions (treatment episodes), Salford delivered 15,155 and Oldham delivered 16,336.

Most complex radiotherapy is done on the Christie site but Salford undertakes some specialist treatment for brain cancer. The radiotherapy department is involved in research both nationally and internationally and many radiotherapy techniques, currently in use, were developed at the Christie. Early next year the trust will start to treat patients with a linear accelerator with magnetic resonance imaging and in 2018 proton beam therapy treatment will be used for appropriate patients including children. The imaging will improve outcomes for patients and future studies will show if this technique will produce better outcomes and a reduction in late effects.

We conducted a comprehensive inspection at the trust on the 10,11,12,13 of May 2016 and an unannounced inspection on the 25 May 2016 and visited the sites at Oldham and Salford as part of the inspection. We spoke with the radiotherapy manager, two superintendent radiographers, the quality lead for radiography, two

specialist radiographers, a pre-treatment radiographer, a floor radiographer, a band 6 education lead radiographer, a medical physicist and two radiography students at the Christie site. We also spoke with the lead oncologist for radiotherapy, a specialist registrar in clinical oncology, a theatre sister and two band five nurses and a health care assistant in brachytherapy and three administration staff and a band two porter. We also met with four patients and four carers, in the proton team we met with the lead radiographer, the lead physicist, the pre-treatment radiographer and the project manager. At Salford we met with the lead radiographer, a review radiographer, a radiographer lead for the stereotactic service, a physiotherapist from the lymphedema service, two band three administration staff and three patients and their carers. At Oldham we met with the lead radiographer and two reception staff. We collected eight "tell us about your care cards" for radiotherapy services at the listening event before the inspection.

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Summary of findings

- The radiotherapy department at the Christie hospital delivered safe, responsive and highly effective services to their patients. The equipment and techniques that they used were cutting edge and were improving all the time.
- There was a focus on research and clinical trials and the department and the trust strived for better outcomes for patients and to reduce the short and long term effects of radiotherapy.
- There was evidence of good multi-disciplinary working and continuing education for staff. Members of both the medical physics department and the radiotherapy staff had studies published in peer reviewed journals and staff were encouraged to share their knowledge and skills at national and international conferences.
- Staff were very caring and patient focused, patients were treated holistically and there was an emphasis on maintaining well-being both physically and mentally. A range of complementary therapies and psychological treatments were available to patients and their carers. All staff worked well together to get the best outcome that they could for the patients in their care.
- The department met their targets and strived to improve so that they treated patients at greatest need in a timely manner. However due to increasing demand for radiotherapy treatment staff were having to work for longer hours to ensure that patients were treated and this had led to poor staff morale amongst the treatment radiographers. The manager of the service was aware of this and was working with staff to address the staffing issues.
- Governance and quality assurance processes were good and there were very few complaints in the department; however the radiotherapy manager, who had not been in post long at the time of the inspection, was working to improve all aspects of the service.

Are radiotherapy services safe?

Good



We rated the safe domain in the radiotherapy department as good because

- There was good incident reporting in the radiotherapy department and staff knew how to report incidents on the trust electronic system. The department had reported two ionising radiation (medical exposure) regulations in 2015, these incidents had been investigated and the outcomes were disseminated to staff at all the sites. The department learned from incidents and changed practice as a result of incident findings.
- The linear accelerators that delivered radiotherapy to the patients were checked daily by the medical physics team and there were schedules of maintenance for all equipment in the department.
- Mandatory training levels were meeting the trust target of 95%. A change in trust policy meant that some staff needed to be trained to level three in safeguarding and there were schedules of training for those who needed it. All other staff had completed their appropriate levels of training for children and vulnerable adults. There were robust procedures in place for dealing with urgent cord compressions both in and out of hours.
- The environment was visibly clean and tidy with hand gel available across the department; medicines were stored appropriately and safely.

However

- Staffing was good at Salford and Oldham however at the Christie site the radiography staffing of the treatment floor was challenging and staff were working additional hours on a daily basis to ensure that all patients received their treatment and morale was low. Radiography staffing in other areas of the department was better. There were also problems with staffing on the reception areas, however the newly appointed manager of the service was aware of all the staffing issues and plans were in place to review departmental needs.
- All appropriate radiographers need to be trained to level three for safe-guarding of children and young people.

Incidents

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- There was good incident reporting and an electronic system in the trust to report incidents. Staff knew how to report incidents and their role in relation to this. The radiotherapy department had notified the Care Quality Commission about two ionising radiation (medical exposure) regulations (IRMER) notifications in 2015 for radiotherapy treatments. Both of the incidents were fully investigated and the findings were discussed at the weekly liaison meeting, the superintendents meeting and staff meetings across all sites. There was evidence of discussions with the patient and their families. The IRMER team commented that the Christie often 'buddy up' with colleagues from another cancer trust (oncologist, radiographer or physicist) to join in with the investigation meeting to offer comments, share experiences and generally help them to mitigate against a repeat. The IRMER team also commented that they often got a phone call to notify them of an incident before the notification was made.
- There had been an incident at one of the satellite sites and an older person had fallen following treatment and sustained a fracture. Following an investigation, lessons were learned and the wording of paperwork was changed to mitigate against this happening again.
- In the brachytherapy therapy theatre there was an incident when the World Health Organisation, (WHO) checklist had not been completed before the theatre list, following this there was an audit of the checklist and close monitoring of the completion of the checklist. One of the nurses on the unit described how she would apply the duty of candour. Another nurse told us about the learning from an incident in which a patient had a reaction to a blood transfusion.
- The clinical oncology trainees were aware of the duty of candour and all staff that we spoke with were aware of the principals of the duty of candour.
- The band three staff at the Christie site said that they would go to their manager to report incidents.

Cleanliness, infection control and hygiene

- Hand washing gel was available throughout the radiotherapy department at the Christie site and patients we spoke with said that the unit was immaculate.
- In the brachytherapy unit there were monthly infection control audits and sharps bins were regularly checked.

- The units at Oldham and Salford were visibly clean and tidy and Oldham had its own housekeeping staff. Hand washing gel was readily available across the department, as was personal protective equipment.

Environment and equipment

- The radiotherapy department at the Christie site was large and modern looking with good use of space for dedicated sections of the department.
- There were eight linear accelerators (linacs) plus a research linac at the Christie site. The machines were all made by the same manufacturer. There were two linacs at each of the satellite sites at Oldham, the machines at Oldham were the same as at the Christie site but the linacs at Salford were made by a different manufacturer. Machines were matched in each location so that patients could be transferred from one linac to another in case of a breakdown or essential maintenance. There was a policy about transfer of patients between machines to ensure that patients received the correct dose of radiation for their treatment. The linacs were checked daily at 7 am before patients were due in for treatment; the checks were to ensure that patients received the correct dose of radiation and that the lasers used to correctly position patients were accurate. We saw evidence of the quality control checks for each linac in all locations and the device check due report and the engineering service schedules.
- We saw that the local rules for radiotherapy were available at all the sites, at Salford the rules had recently been revised and were out so that staff could read them. This was part of the IRMER regulations. There were radiation risk assessments for the computerised tomography (CT) simulators and for each linac which were reviewed every three years. There were also risk assessments for pregnant workers and new mothers.
- There was a quality manual to provide guidance to safely verify treatment delivery for different imaging and treatment and in vivo dosimetry protocols for each linac.
- One of the suites on the radiotherapy unit was for paediatric use and general anaesthesia was administered in the room, it was decorated appropriately for children but there was a lot of equipment in the room. Staff said that the new build for proton beam therapy, where the majority of paediatric patients would be treated, would be much more child friendly.

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- The rooms in which planning for radiotherapy was done had quiet signs on the doors, this was because treatment planning required a great deal of concentration and staff could not be disturbed.
- Defibrillators and resuscitation trolleys were placed around the department, we checked two during the inspection, one had been checked on the day of the visit and there were records showing that it was checked daily, the other had not yet been checked that day but records showed that it had been checked daily.

Medicines

- Saline and contrast media were kept in a locked cupboard in one of the planning rooms in the radiotherapy department and in a locked cupboard in a storage area. In this cupboard was another locked cupboard for the storage of controlled drugs. There was no patient access to these areas. There were thermometers to measure the temperatures of the rooms. These medicines were the responsibility of the pre-treatment radiographers and were checked weekly by one of the permanent radiographers on this team. We saw records of stock checks of medicines including controlled drugs. There were emergency medicines in the scanning rooms where contrast media was used, as there was a possibility that patients could have an allergic reaction to the contrast media. The medicines were available in each scanning area in a tray that was accessible to staff and was locked away at the end of the day.
- There were patient group directives for administration of contrast media and other medicines that could be administered by staff who were supplementary prescribers. Some radiographers at Salford and Oldham were supplementary prescribers for medicines to support people during and after radiotherapy treatment. The radiographers were about to become independent prescribers and they said that this would speed up the process of prescribing and it would become more efficient
- Fridge temperatures and room temperatures were monitored and audited in the brachytherapy suite.

Records

- There was an electronic radiotherapy record system which was also used for chemotherapy records. Referrals for radiotherapy were received through the

Christie web portal, though a few trusts were still using paper records. Treatment summaries were entered into the Christie web portal manually so that staff at other hospitals on the web portal could access information about histology, imaging and scanning and pathology of their patients.

- Paper medical notes were used in the outpatient departments and during radiotherapy treatment these were kept in the department in areas not accessed by patients in locked trolleys.
- The trust was using an electronic system for the planning and monitoring of radiotherapy treatment for patients.

Safeguarding

- All the radiographers had level two training for safeguarding adults and children and young people though it had been agreed that some of the trained staff needed level three training in safeguarding children, certain staff were being prioritised for this training and it was due to be rolled out to staff in the next few months.
- The paediatric radiographer was trained to level three for safeguarding for children and young people, she was a member of the trust safe-guarding committee and had access to serious case reviews, the safeguarding log and learning reviews and was responsible for the dissemination of this information around the radiotherapy department. Staff who accompanied children and young people into the hospital for radiotherapy treatment were trained to level three for safe-guarding children and young people.

Mandatory training

- Mandatory training levels for radiographers were at 95% across the sites and had not gone under this level for 18 months. The staff involved in staff training had access to the electronic trust training records of the staff and organised e-learning sessions for all the staff. Every staff member in radiotherapy had a training file which was kept in the dedicated training room and an electronic training record.
- There was mandatory training for staff that consented patients every three years and a lecture on consent from the trust solicitors every year.
- A need had been identified for paediatric life support training and this has been outsourced for the personnel involved in the treatment of children and young people.

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- The radiotherapy manager and the training radiographer commented that mandatory training such as lifting and handling and basic life support was designed to fit around nursing shifts which were not always appropriate for the radiography staff.
- All the brachytherapy staff had completed their mandatory training.

Assessing and responding to patient risk

- Each of the treatment suites had CCTV of the waiting room so that staff could observe patients to check on their well-being. The radiographers we spoke with had a clear knowledge of who to contact if patients had any problems. All the doctors names and details were on the trust intranet and the specialist radiographers were also available for advice
- There was a good cord compression pathway for the local cancer network and all patients at risk were given a hotline number if symptoms occurred. Patients could be treated at Oldham and Salford as necessary.
- There was a cardiac arrest team at the Christie if there was a medical emergency and staff who administered contrast media to patients had training in intermediate life support. It was a band 6 competency of the radiographers to administer contrast media. At Oldham and Salford, staff could access the cardiac arrest team on the main hospital sites for emergencies if necessary.
- There was a policy for radiation risk for women of child bearing age and those who were breast feeding; we saw signs in the treatment areas and in the changing rooms at all sites asking women to inform staff if there was any risk that they may have been pregnant.

Radiotherapy/ medical physics staffing

- At the Christie there were 19 band 5 radiographers, 37.5 (full time equivalent) FTE band 6 radiographers, 13 band 7's, superintendents and specialist radiographers, four principal radiographers and the service manager. While the staffing in pre-treatment of radiotherapy was sufficient, staffing to cover services provided by the treatment radiographers was challenging. Staff worked either 8am to 4pm or 10am to 6pm and the last appointment should have been 4.30pm. There needed to be at least two radiographers on each linac at any one time to ensure patient safety and during the busy times there were four radiographers who worked as a team. Due to increasing demands on the service, staff on the later shift had to work additional hours every evening to

ensure that all patients were seen and although staff were paid for this work morale was low. Waiting lists were not an option for this service and the work of the radiographers required high levels of concentration to ensure that patients received the correct dose of radiation. The service was safe for patients currently, but if the heavy workload continued there was a possibility that patient safety could be affected. Students who worked with the radiographers said that they felt that they were holding things up as they were slower than the trained staff and that they were struggling to get their competencies signed off for their training. The morale in the pre-treatment and review radiographers was much better. The staffing issue was on the risk register.

- The radiotherapy team manager said that due to a trust policy of recruiting band 5's to replace band 6's the skill mix had changed in the department. The band 7's had little time to support staff as they were often involved with service delivery rather than training. Radiotherapy was becoming more complex and imaging had to be done by band 7's. This was also slowing down the implementation of research. The preferred option would have been for a band 7 on each linac to support training for staff and students but there were not enough band 7's to cover this. To compound this, the most complex work was centred at this site. Some appropriate patients were given the choice to attend for treatment at the satellite sites but some said that they would prefer to stay on the main site. The manager said staff development and progression was difficult and that it was difficult to recruit higher banded staff (7/8A) and that students were not always given a good learning experience at the Christie site.
- The medical physics team were responsible for the treatment planning for radiotherapy and brachytherapy and the quality assurance of the linacs and staffing was adequate. There were just under 78 FTE staff consisting of radiographers/dosimetrists, clinical scientists and engineers. They were managed by a medical physicist but were in a different directorate than the therapy radiography service. The physicists worked 7am to 3pm and 11am to 7pm so that there were always available to deal with any problems with the linacs.
- There was a mould room that was under the management of the radiotherapy department with two

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technicians and an assistant practitioner, they were part of the pre-treatment team. The radiotherapy staff were rotating into the mould room. Moulds were used mainly for patients with head and neck cancer.

- The band three reception staff at the Christie said that they were understaffed and the reception desks were not always staffed; they were sometimes booking in over 250 patients a day which left them with little time to do their other duties. As staff had reduced their hours they hadn't been replaced and there was no cover for sickness and annual leave. The newly appointed radiotherapy manager acknowledged that there were problems with the reception staffing and that this would be reviewed as part of the meetings he was having with all staff.
- There were two band 2 staff who acted as porters taking patients to and from the wards and taking specimens to pathology. They said that there had been more staff but they hadn't been replaced when they left. Their role ensured that patients were in the department in time for their treatment. We spoke with one of them who said that he was disappointed that his role could not be extended to support the reception staff and other tasks and he said he thought there should be more opportunities for career development.
- There were band 3 linac support workers who assisted with patients and helped in the mould room.
- Radiography staffing at the Oldham site was good. Staff were not rotational and at Oldham there were 14 radiographers, two superintendents and the manager. They could backfill for training, annual leave and sickness from the existing staff though they had some temporary cover for maternity leave. There were two physicists, one was a fixed post and the other was rotational.
- The staffing at the Salford site was good, there were 19 radiographers including the manager. The specialist nurse post in the review team had been vacant for a number of months and the review service had been run by a review radiographer and a doctor. This had been on the department risk register. A new member of staff was due to start in June and this would ease pressure in the review service. There were four linac support workers who helped to make the masks for patients who were having radiotherapy for head and neck cancers, they also chatted to patients to reassure them and to check if they had any requirements that needed feeding back to the radiographers.

Brachytherapy staffing.

- There were six dedicated nursing staff in the unit including the manager and a health care assistant. The staff would back fill in theatre if they were quiet but the theatre list in the unit was never cancelled.
- There was a pool of theatre staff that would cover for sickness and annual leave.

Medical staffing

- There were ten clinical oncology trainees who were on a five year training programme which rotated between the Christie and Preston. Posts for this training were unlikely to be filled nationally.
- There was a clinical lead for the Oldham site and there was a rapid response consultant at the Oldham site on three days a week. Other transient consultants would attend the site during the course of the week. At Salford there was consultant cover four days a week.

Major incident awareness and training

- The manager at the Salford site attended major incident meetings which looked at how the department would support a major incident; she said there had been a recent table top exercise that she had been involved in.

Are radiotherapy services effective?

Outstanding



We rated the radiography department as outstanding in the effective domain. This was because:

- There were protocols in place and treatment was planned and delivered using best practice and national guidelines. The trust were committed to the delivery of individualised treatment and to improving outcomes of radiotherapy for patients. There were regular audits both locally and nationally and the trust published outcome data for a variety of cancers on its website.
- The trust and its partners have been involved in research into radiotherapy techniques for many years and this work is recognised nationally and internationally. Staff were funded for post-graduate education and were encouraged to write for peer

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reviewed journals and to present posters at conferences including international conferences. There were large numbers of clinical trials and many patients were involved in these trials.

- The department was using new radiotherapy techniques including image guided radiotherapy (IGRT) and intensity modulated radiotherapy (IMRT) to improve outcomes for patients. They also used volumetric modulated arc therapy (VMAT) stereotactic body radiotherapy (SBRT) and stereotactic radiotherapy/radiosurgery (SRS)
- The department participated in national audits and used National Institute of Health and Care excellence (NICE) guidelines for the delivery of their services. There was up to date equipment and a replacement schedule for all equipment. A new magnetic resonance linear accelerator was due to be operational early next year and a proton beam therapy unit in 2018. Both of these pieces of equipment would reduce the late effects of radiotherapy for patients including children.
- There was excellent multi-disciplinary working across the three sites and robust induction processes for radiographers on the linear accelerators. Appraisal rates were good for the radiographers. Consent procedures and training were robust for all staff including the specialist registrars and the specialist radiographers.

Evidence-based care and treatment

- There was a legacy of research at the Christie that included the development of systems and techniques that are currently used in radiotherapy treatment.
- There was a Christie Radiotherapy Related Research (RRR) team and many members were academics or honorary academics in the RRR centre of the Institute of Cancer Sciences. The University of Manchester, Christie and Institute of Cancer of Sciences researchers had combined with academics in the School of Pharmacy at the University of Manchester to form the Manchester Cancer Research Centre (MCRC) RRR group in 2007; the group which met monthly as a collaborative and collegiate group and had a strong national presence. They were one of three centres of excellence for radiotherapy research in the UK.
- Two world leading academics had been appointed as part of the expansion plan for radiotherapy research; one was for the magnetic resonance imaging linear accelerator (MR linac) for research into lung treatments

and the other was leading on the national proton research agenda. The Christie is one of seven units in the world to have access to the magnetic resonance linear accelerator (MR linac)

- Some of the research involved the investigation of complex radiation drug combinations in the laboratory and the translation of these findings into clinical trials. There was also research for advanced radiotherapy delivery and imaging.
- The Christie had the largest brachytherapy practice in the UK, they treated 330 patients a year with gynaecological cancers, the minimum requirement for treatment numbers was 30. They used state of the art image guided brachytherapy (IGBT) with MRI scanning to plan the procedure; the lead clinical oncologist for radiotherapy had been to Vienna to train with world experts in this technique. Brachytherapy was also used the treatment for prostate cancers and some skin cancers and the trust were planning to offer treatments for larger and more aggressive tumours.
- The stereotactic service (SRS) at Salford was internationally recognised for the standard of care that was provided to patients and the commitment to patient safety. The Christie was one of the first centres in Europe to have certified accreditation for the treatment and was working with the Greater Manchester neurosciences centre. The satellite centre had been part of a national tendering exercise with another local trust to provide SRS; they had been successful in the tender and were working with the other trust to combine protocols and joint data collection for outcomes with the other centre.
- The area had a large cancer population who had received radiotherapy treatment including stereotactic which made them ideally placed in the UK to perform clinical radiotherapy research.
- There were articles in peer reviewed journals including ten from the medical physicists and a number of abstracts and posters from radiologists, radiotherapists, dosimetrists and clinical scientists. Staff were funded to present their research at conferences both nationally and internationally.
- The trust participated in a number of national audits including the head and neck cancer audit, the bowel

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cancer audit, the lung cancer audit and the

oesophageal and prostate cancer audit. Each tumour site group had a research lead in clinical oncology and there were over 40 of these at the trust.

- There was a clear pathway for rapid access spinal cord compression for the local cancer network that followed National Institute of Health and Care excellence (NICE) guidelines.
- The quality system set the protocols for each treatment. Only consultants could go off-protocol and there was an off protocol form that required the reason and the justification for the treatment. Their signature was required for any off protocol treatment and the physicists were always involved in any change in dosage.
- The Christie participated in large numbers of clinical trials and there was training for radiotherapists taking part in trials. There were 3.8 full time equivalent (FTE) radiographers involved in research and two funded medical physics staff though the lead oncologist for radiotherapy felt that this was not enough if the trust wanted to be in the top flight of research in the world. Following approval for research and clinical trials there was a delay in the implementation because of this shortage of staffing.
- In 2013/14, one in five out-patients had taken part in research and 20% of patients who had consented to be part of a research study were involved in more than one trial.
- There was a Manchester proton group who were working with patients who had proton treatment overseas.

Pain relief

- The radiographers discussed pain with patients at each visit and could prescribe appropriate pain relief as necessary as many of the radiographers were supplementary prescribers. Pain relief for patients undergoing head and neck treatments were stored in the clinics at the Christie to ensure that patients received their pain relief in a timely manner. Patients also had a review with a consultant or a radiographer and pain was discussed at the reviews.
- There had been a significant improvement in the numbers of gynaecological patients who were able to tolerate completion of their treatment partly due to pain management and the improved environment and staffing.

Equipment

- There were eight linear accelerators (linacs) at the Christie site, two of the linac's were eight to nine years old and were due to be replaced. The trust had an equipment replacement programme. The older linacs were used mainly for palliative radiotherapy as the newer linacs had better imaging for radical (curative) therapy. The linacs at the Christie and Oldham were from the same manufacturer and the linacs at Salford were from a different manufacturer.
- There was a new MR linac which was due to be on line for research patients in 2017. There is one other MR linac in the country and seven in the world.
- The brachytherapy unit had two machines, a pulsed dose rate machine and a high dose rate machine.
- There were two computerised tomography (CT) simulators at the Christie site to support radiotherapy planning.
- There was a wide bore (CT) simulator and a virtual simulator at Oldham for the planning of patients' treatment and two linacs for treatment
- At Salford there were two CT scanners for planning and two linacs for treatment. The radiotherapy department in Salford was one of 17 nationally who were commissioned to perform stereotactic ablative radiotherapy (SRS). This stereotactic radiation therapy is used to treat brain tumours and stereotactic body radiation therapy (SBRT) is used on tumours of the body. It is highly focused radiation treatment that gives an intense dose of radiation concentrated on a tumour, while limiting the dose to the surrounding organs.

Nutrition and hydration

- It was important for patients to maintain their weight during treatment as significant weight loss could result in the treatment prescription having to be adjusted due to the accuracy needed in treatment planning and delivery. Patients were reviewed by consultants or the review radiographers/nurses and weighed every week and if necessary and food supplements were prescribed. It was also important that patients were hydrated and advice sheets were given about how much water they needed to drink every day.

Patient outcomes

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- There were protocols in place and treatment was planned and delivered using best practice and national guidelines. The trust were committed to the delivery of individualised treatment and to improving outcomes of radiotherapy for patients.
- The department was using new technologies and techniques in the pre-treatment and treatment phases of treatment. This included CT planning image guided radiotherapy (IGRT). This used three dimensional cross-sectional scanning which gave better definition of soft tissue and any changes in the position of tumours. IGRT was more effective for the planning of radiotherapy and so patients suffered fewer side effects from the treatment.
- The Christie was the earliest implementer of intensity modulated radiotherapy (IMRT) in 1999, this was used in the treatment of patients and is a specialised way of delivering radiotherapy. It uses many small beams to target the tumour from a number of angles and gives a degree of targeting that cannot be obtained with conventional radiotherapy. IMRT provides better outcomes than that of conventional treatments. The NHS commissioning clinical reference group stated that Intensity Modulated Radiotherapy (IMRT) was the gold standard of care and that 33% of all radical treatments should be delivered with IMRT, the trust were delivering 47% by IMRT in April 2016.
- The department also used volumetric modulated arc therapy (VMAT) which allowed all treatment be delivered more efficiently to maximise the radiation dose to the tumour while minimising the overall dose to the surrounding tissue, thus providing better outcomes for the patient.
- Stereotactic ablative radiotherapy (SRS) and (SABR) were also being used; this radiotherapy focused volumetric modulated arc therapy in high doses to the tumour and was used to treat small primary tumours and metastatic cancers which are cancers that have spread including metastatic brain tumours. This technique for the treatment of metastatic brain tumours enabled each individual tumour to be targeted and was an alternative to conventional whole brain radiotherapy. It could be an alternative to surgery or where surgery is not an option because of the location of a tumour or for the control of symptoms.
- There was an increased use of combined chemotherapy/radiotherapy for patients who would not have previously been suitable for radical treatment.
- The trust were using a national clinical pathway for suspected and confirmed lung cancer which contained details of referral to treatment.
- There was a rapid access cord compression team that included a radiographer and a physiotherapist as part of the acute oncology team, they were supplementary prescribers. This meant that patients were seen in a timely manner and their pain symptoms were treated appropriately. The lead clinical oncologist for radiography said that there were still improvements that could be made to the pathway for treatment in terms of access and referral and the nurses involved in the hotline to the service were attending consultant meetings.
- There were three specialist radiographers, one worked with paediatric patients while the other two worked with urology and colo-rectal patients respectively They consented patients for treatment with radiotherapy and chemotherapy and they ran their own review clinics for patients undergoing radical (curative) treatment for bladder and prostate cancers. One of the radiographers had surveyed other radiographers in the department about their service and feedback showed that the radiographers felt that there was better continuity for patients in the radiographer led service. The paediatric radiographer worked with children with neurological conditions and some adults. They referred patients (30-40 per year) to the proton beam centres in the USA and they followed the patient along the proton beam pathway. The radiographer had visited these centres to facilitate the patient journey and had excellent communication with their clinicians and radiographers.
- The specialist radiographers worked closely with the specialist registrars and the consultants and they had a meeting every three months. There was a shortage of specialist registrars and this role went part way to filling this gap taking the more routine patients while leaving the more complex patients for the registrars. The specialist radiographers liaised with the radiographers treating the patients on the linacs giving support to patients and they were a resource for staff. They were supplementary prescribers and could prescribe creams and change medication if necessary and could also do observations of patients who were acutely unwell. They sat on the skin care committee of the trust and were training staff about appropriate dressings. They had presented at conferences on the advanced practice role

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and were involved in teaching at two universities and were also involved in teaching the specialist registrars. There were opportunities for the development of this role in other specialities including head and neck cancer (some staff had completed modules to support this), lung cancer, upper gastro-intestinal cancer, sarcoma and skin and the replacement of the breast cancer specialist radiographer, the development of these roles would need peer support from a range of consultants and other health professionals.

- Patients were reviewed by the clinical oncologist during the course of the radiotherapy treatment. They determined the frequency of the review and recorded patient progress. They also reviewed and altered the external beam therapy prescription if indicated and arranged for follow up. The review could be delegated to specialist staff including nurse clinician/practitioner and specialist radiographer. There were review teams at the satellite centres that included a radiographer and a nurse specialist and a doctor. The radiographers who carried out the radiotherapy treatment would report any problems or issues to the person reviewing the treatment.
- There was a radiographer with a lead for the promotion of a healthy lifestyle package for head and neck patients during radiotherapy. The radiographer had been trained in alcohol awareness, smoking cessation, hypnotherapy and communication techniques. They could then support those head and neck patients who were smoking, drinking alcohol, using drugs and had poor oral hygiene during their treatment to try to improve their outcomes.
- The specialist radiographers had to maintain their competencies on the linac's to fulfil the on call rota and had management duties including staff PDR's. They were also involved in research.
- There was also an excellent physiotherapy lymphedema service at all the sites for those who had received treatment for breast cancer. At Salford all patients were given an appointment for the service. These appointments were on a one to one basis with advice and exercises for patients, there was good compliance because of this and the patients could see the physiotherapist following their radiotherapy treatment twice weekly if they wished to. Feedback from patients was good. Although not all patients suffer from lymphedema following treatment, patients found it helpful that they were made aware of the symptoms

and limb measurements were taken so that compression sleeves could be prescribed in a timely manner. The lymphedema service at the other sites was a group class with one to one advice if necessary. All the lymphedema services could refer to services in other trusts.

- One of the quality measurements set by the trust included 30 day mortality following palliative radiotherapy. In October 2015 these were 91% and in November 2015 they were 88%. These figures were within trust targets.
- The MR linac will be used to give better contouring of the tumour and the organs at risk as there is better soft tissue contrast. This will be useful in treatment of the prostate to avoid organs at risk including the bladder and the rectum. The MR scanner is also better for paediatric scanning and for patients who need a restriction of radiation as MR scanning does not use radiation for scanning purposes. Scanning is usually carried out on CT scanners which scan by using radiation.
- The trust had been successful in tendering for the stereotactic service (SRS) based at the Salford site in partnership with a nearby acute trust. Staff were working to combine protocols and look at data collection for patient outcomes.
- There was a clinical outcomes department and the trust published outcome data on its website for a number of cancers.
- The department was using the NICE guidelines for improving the outcomes for people with brain and other central nervous system tumours with the SRS service at Salford.
- The Christie has taken a role in making brachytherapy treatment safer and documenting late effects and outcomes which is internationally published data. There continued to be research into the most effective dose for these patients.
- The proton beam therapy team were looking at outcomes collection from patients and how this could be done with the referring hospital. The treatment allows a higher dose of radiation to a tumour but there is a reduction in late effects which makes it the treatment of choice for children and young people. It would be used to treat paediatric patients, head and neck cancers, sarcoma and tumours of the central nervous system and is complimentary to other treatments.

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Competent staff

- There was an education team in the radiotherapy department which included a member of the treatment team on rotation and two band 7's, there was a vacancy for an 8A. They were responsible for the education of the qualified staff and some of the student training. The training records were electronic and each member of staff had their own file in the training room.
- There were link radiographers at each site who took responsibility for different areas including mental health, infection control and suction techniques. They linked to core services in the trust and undertook training for the other radiographers.
- The pre-treatment radiographers said that training was constant to get competencies signed off for the staff and students, they worked closely with the clinical skills team in the trust for initial training such as cannulation and then in the department for sign off of competencies.
- Radiographers rotated through medical physics/ planning for their development.
- There was a comprehensive induction for new staff; the process was for five to six weeks for any radiographer who had not trained at the trust and three weeks for those who had. There was a week training on the machine and then on the various techniques. Competencies were signed off at weekly intervals and at week five there was a meeting to assess where staff were up to and an assessment of any further training needs. Feedback from staff was that they were not moved around between different linacs too regularly. There was preceptorship for newly qualified staff.
- The radiographers at Salford had to maintain their competencies on different linacs if they were on the on-call rota
- Staff were encouraged to complete post-graduate degrees that met the development needs of the service; these were funded by the trust. At the time of the inspection 18 radiographers had completed their post-graduate degrees and 18 were part way through their courses.
- The manager said that there was not yet enough training in place for the MR Linac and the photon beam therapy treatment.
- Appraisals were carried out for new trust members at the end of the three month probation period and then at six months and 12 month intervals. The appraisals were carried out by radiographers who were of a higher band.
- All the staff in the medical physics/ planning team had completed their appraisals and personal development plans. There was good development for staff and the department and the team worked closely with a local university. Staff had three continuous professional development days every year and some the team were involved in teaching in India. Staff were encouraged to gain a degree at post-graduate level in their areas of interest and the manager was working towards a management degree at post-graduate level which was funded by the trust.
- A skin care training event had been put on with input from a dermatologist and staff from a burns unit. Radiotherapy treatment can cause burns during treatment.
- New consultants had fed back that they could sometimes feel quite isolated and so arrangements had been made for the new consultants to share offices with more experienced consultants. The junior doctors gained experience by attending consultant meetings and trust committees such as the audit committee. All doctors attended management courses to develop their management skills.
- We spoke with a clinical oncology trainee; she described the consultants as very supportive and felt that the Christie gave her exposure to a large patient base which would give her experience. She said it was very busy but that she covered ward work and clinics and that the planning training for gynaecology and lymphoma was good and that they were involved in trials for new treatments. She also said that the Christie now working to international standards which made getting a post at another hospital easier.
- The nursing staff on the brachytherapy unit said that there were a lot of learning opportunities and one of them was being sponsored to learn about the treatment, she was a band 6. They said that the consultants were very tolerant and did a lot of teaching during procedures. The department was considering the development of an advanced nurse practitioner role to improve patient flow and to reduce the need for doctors on the unit. The band 5 staff rotated through the

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different areas of the unit and described good induction into each area. Staff described it as a good supportive place to train and very rich in terms of training opportunities. All the staff we spoke to in the brachytherapy department had their appraisals completed with their line managers. The health care assistant had recently been trained to take blood and was pleased that she had gained this additional skill.

Oldham and Salford

- At Oldham and Salford the radiotherapy staff were trained in all aspects of pre-treatment and the delivery of radiotherapy treatment. This included making moulds for head and neck cancer patients and those having SRS treatment. As the staffing group was smaller and most of the staff did not rotate they had to be competent for all areas of treatment and use of the linacs.
- The radiotherapy staff from Oldham and Salford could use the training facilities at the Christie and they did some of their site specific training there. The reception staff had completed the Christie care certificate which included training on safe-guarding, dementia, nutrition, observation and general patient care and all of the reception staff had a personal development plan with objectives and review dates.

Multidisciplinary working

- There was a multidisciplinary team room with video conferencing and a weekly meeting with the satellite sites.
- One of the radiographers described a great relationship between physics and radiotherapy though the specialities were in different directorates.
- The cord compression team included a physiotherapist and a radiographer as well as the clinical oncology team. This helped with the mobilisation of patients.
- All the radiotherapy services worked with a range of specialist nurses to support patients, we saw the tissue viability nurse in the radiotherapy unit, she had been asked to treat a patient who was having radiotherapy treatment.
- The radiographers at Salford described good relationships with the acute oncology nurses and consultants on the main hospital site. They also worked with social services to support patients who needed equipment and adaptations.

- The proton beam therapy team were working with referring centres looking at referral pathways and engaging with the wider community.

Seven-day services

- The radiographers were on call for seven hours Friday evening and 24 hours Saturday/Sunday and bank-holidays. Radiographers were not usually be asked to come in after 8pm but had to be contactable to respond to a call at all times covered by the on-call period.
- There was no on call service at Oldham and Salford but some of the radiographers working at the satellite sites were on the on call rota for the Christie.
- If there was notification of a spinal cord compression a consultant clinical oncologist had to approve the emergency call out and plan the treatment; the on-call specialist registrar would confirm approval for treatment with the consultant and arrange for the patient transfer and admission for treatment. They would inform the on-call radiographers of the emergency treatment required and plan the treatment according to clinical oncology guidelines and protocols.
- Existing radiotherapy patients were treated on bank holidays to ensure continuity of treatment.

Access to information

- The radiotherapy service used an integrated information system for their service; there was a data shunt from the radiotherapy system to the hospital patient administration system (PAS) and vice versa so that each system had access to information about the patients.
- Staff said the Christie web portal was good and would be available in their partner trusts in the near future enabling staff at these hospitals to have appropriate access to access to patient treatment records from the Christie.
- The proton beam therapy team were working with partners to develop a referral portal.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were site specific with benefits and significant, unavoidable or frequently occurring risks on them. The patient signed to say that they had received the appropriate leaflets and tapes. There was also a section for the signature of the interpreter where appropriate which indicated that the interpreter had

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interpreted the information on the form to the best of their ability and in a way that the patient could understand. Consent could be given by specialist radiographers and nurse clinicians within radiotherapy. Exclusions to this included patients less than 23 years of age, patients who were pregnant or where there were fertility issues and patients who were unable to consent.

- Registrars did not consent patients for treatment until they had achieved competency, this involved assisting with 50 consent procedures.
- Patients who had their multi-disciplinary team meetings (MDT) at the hospital were already consented before they arrived in the department; patients who had their MDT meeting outside the hospital were seen by the consultant before treatment.
- A consultant oncologist gave examples of best interest meetings for patients without capacity including one for a patient with a learning disability and one for a patient with dementia; the trust dementia consultant nurse was present at the meeting. One of the clinical oncology trainees described how she had used consent form four (consent for people without capacity) for a patient with dementia who required treatment for spinal cord compression.
- All the radiotherapy staff had received DOLs training.

Are radiotherapy services caring?

Outstanding



We rated the radiotherapy department as outstanding in the caring domain. This was because

- Each patient was assessed and treated on an individual basis and their unique needs were responded to. As treatment often continued over days and week's staff built up a relationship with the patients, carers and relatives and understood and responded to their needs.
- Staff treated patients holistically and provided emotional support when necessary. The specialist radiographers were aware of their vulnerable patients and contacted them to check on their well-being between appointments. The review radiographer at

Salford always had her office door open so that patients could pop in for a chat and advice. Reception staff knew the patients and greeted them by name as they arrived in the department.

- Counselling services were available for patients and their relatives and we spoke with patients who had been referred to these services and found them beneficial. Staff used screening tools to monitor patient's anxiety and stress. The staff on the brachytherapy unit were very caring and supported patients during their treatment.
- Patients we spoke with had said that they had received good explanations of their treatment and that they felt involved in their own care. They said that the staff had explained side effects of the treatment with them. They described staff as very caring. Another patient said that they had been in at least four hospitals and this was the best one.
- At Oldham there were open evenings for patients and the staff were working with local charities. The local mosque had donated funding to the centre and an open evening had been arranged for the children and young people from the mosque to look round the centre. The centre had been nominated for a community award.

Compassionate care

- The reception staff on the radiotherapy unit were the welcoming face of the unit and they grew close to some of the patients having treatment in the unit. They helped patients and their relatives with any questions and queries and fed back to the radiographers if necessary. There were many thank-you cards on display that they had received. The reception staff at Oldham and Salford welcomed patients by name as they arrived in the centres.
- There was a lead radiographer who was a lead for friends and family who linked in to the patient experience committee.
- Patients who required chemotherapy and radiotherapy were seen early in the day for radiotherapy before starting chemotherapy. This meant that that the treatment was more comfortable for the patient without a drip.
- The review radiographer for prostate cancer had undertaken a survey about the service that included a patient satisfaction survey. The response to the survey included comments such as "excellent service by very dedicated staff", another said "my specialist is first class,

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I've been in at least four hospitals and this is the best one" and a third said "I was well informed over cumulative side effects over time which I had not read anywhere".

- We spoke with a patient and two carers who said that the hospital was friendly warm and caring, they said that staff approached them in the hospital if they looked lost and that the hospital created a therapeutic environment for patients and carers. Another patient had arrived early and was treated early, she said that cancer was a journey for families and friends and patients. She was comfortable with her treatment but sometimes felt alone.
- On the "tell us about your care" feedback cards patients said that the service was very good and that they had been treated with dignity and respect. Staff were described as wonderful and caring.
- Nursing staff on the brachytherapy unit said that they could spend extra time with patients as they weren't always too busy, they said that patients came back to thank them and that this made them feel good.
- During the inspection the brachytherapy theatre temperature was too low for patient comfort and so the theatre list was delayed until the theatre temperature had come up to above 18°C.
- There were open evenings at the Oldham unit for patients and families and staff volunteered for this. Any feedback was used to improve the service but the only negative feedback was that the open evenings were only once a month. There were also open evenings for charity groups who had donated funding to the unit, one of these groups was a local mosque and the youth group from the mosque had been to visit. The service wanted to work with the local black, minority ethnic groups as patients who accessed the service were not reflective of the ethnicity of the local population. The staff at Oldham had been nominated by the local community for the pride of Oldham award, they had come second. Salford also considering starting open evenings.
- A patient at Oldham said that "all the staff are extremely friendly and welcoming" another said "it's wonderful, they explain everything at every stage, you couldn't get better than Oldham" and a third said "I have been hugely impressed by the unit and the staff who are responsible for my care."

- At Salford the review radiographer's office was in the patient waiting area for radiotherapy and patients could informally drop in and ask for advice and support including emotional support.

Understanding and involvement of patients and those close to them

- A patient and her carers said that they had received good explanations about their treatment and that there were involved in decisions about their care. Another patient said that she was looked after and all possible symptoms were explained.
- The radiotherapists were working closely with the relatives of patients with dementia and providing additional support through a "contract of care" ensuring that they were involved in all aspects of decision making.
- The nursing staff in the brachytherapy unit supported patients following treatment when they had to lie flat for 17 hours in a single room; they brought refreshments and chatted with them to try to relieve the boredom. They could give a foot massage to anxious patients and they said that the unit had a very caring atmosphere.
- Nurses in the brachytherapy unit supported patients who had dementia and their families and ensured that they were given extra time if necessary. There were also many young patients who required extra time and support as they were very vulnerable.
- Following the collapse of a patient's relative at Oldham, the radiotherapists arranged a GP appointment for him the following day and arranged transport to bring the patient, who was blind, and the relative in to the centre the following day.
- There was a service for young people whose parents had cancer and there were days out every three months. There was also a one to one service with support from a psychologist or a cancer support specialist for children and young people who had cancer.
- There was a managing stress course for people who had cancer and their families and friends. There were also relaxation courses for patients.

Emotional support

- One of the radiographers had developed additional communication skills for their work in promoting a

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healthy lifestyle package for patients with head and neck cancers, and was able to use these communication skills with empathy and compassion. These skills were also used when treating patients with dementia.

- The specialist radiographers had a holistic view of their patients and would follow up patients by telephone who they considered to be vulnerable before they had their follow-up meeting with the consultant at six weeks following treatment. They also used screening tools to measure anxiety and stress and could refer them for psychological support including cognitive behavioural therapy.
- There was a bell on the wall in the radiotherapy unit so that patients could ring at the end of their treatment, we saw patients having their photographs taken ringing the bell and posting them online for their friends and relatives. Patients we spoke to said that it was a good feeling and that they had looked forward to the day that they could ring the bell.
- A patient we spoke with said that her treatment had been brilliant and that the staff were lovely. She had been involved in a clinical trial and had prolonged chemotherapy and radiotherapy treatment. She said that she had been well informed and had seen the doctor regularly and that her emotional support had been good. Her consultant had referred her for counselling and this had been helpful as she had concerns about how she was going to explain her illness to her young child. She said that this had really worked.
- A Maggie's centre ran support services at the centre but also online, these included bereavement services and there was a bereavement support group.

Are radiotherapy services responsive?

Outstanding



We rated the radiotherapy department as outstanding in the responsive domain. This was because:

- The waiting areas and treatment areas at all the sites were comfortable with contemporary furnishings and artwork around the departments. All areas were light and airy and there was access to café facilities at all the sites. The brachytherapy suite was purpose built and everything had been done to improve the patient experience.

- There were dementia champions in the department and a contract of care had been developed to support patients with dementia and their relatives and carers.
- The three sites provided a range of radiotherapy treatments and had met their 31 day to start radiotherapy treatment for the last four months and had set a target to treat patients with lung cancer in no less than 14 days. They were meeting this target.
- There were a range of complementary therapy services available for patients including a service for patients who needed to wear a mask during treatment. This service helped these patients to be less anxious and to relax during treatment.
- A consultant was doing a pre-trial study where patients could notify staff of any concerns that they had about their symptoms on-line. It was hoped that this would reduce admissions and address symptoms in a timely manner.

Service planning and delivery to meet the needs of local people

- The Christie site delivered standard treatment and stereotactic ablative body radiotherapy, total body irradiation, radiotherapy for paediatrics, complex radiotherapy, chemo radiation and total skin electrons. Salford provided some stereotactic radiosurgery and standard treatment and Oldham provided standard radiotherapy treatment.
- At the Christie site although much of the department had no natural light the space was light and airy with artwork around the department. There were dedicated waiting areas, with reception desks, for the linear accelerators (linacs) and also areas with comfortable chairs, settee's and tables where patients and staff could sit and relax.
- The trust had a 24 hour hotline which was staffed by trained nurses.
- There was a radiographer who had gained additional communication skills; this enabled them to better communicate with patients with dementia.
- The brachytherapy unit had been redesigned and upgraded in 2013. There was a planning office, two brachytherapy machines, a theatre suite and a suite of rooms for patients. The patient rooms were purpose built to make the patient experience as good as it could be with televisions and £250,000 of charitable funds had

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been spent on sky panels for the unit to try to enhance the patient experience. Imaging for treatment was done on an MR scanner which was close to the theatre and there were pre booked slots for patient convenience.

- There was a target so new lung patients who had their planning appointment waited no longer than 14 days to begin their treatment. This was because the condition of lung cancer patients could change rapidly. The sites were meeting this 14 day target.
- The medical physicists had produced a patient leaflet to tell patients what happened in the period between them having their planning scan and the start of their treatment as patients did not understand why their treatment could not start immediately after their pre-treatment appointment.
- The staff in the brachytherapy unit were dedicated to the unit and so procedures were never cancelled. There were theatre lists every day but numbers of patients were often small but procedures were highly specialised. There was a pain list on a Friday. Patients had to lie flat for up to 17 hours following procedures in single rooms with the doors closed due to their radiation levels, the nurses would check on the patients regularly and give them refreshments and check catheters, they would wait by the doors in case the patients needed anything.
- Some of the senior nurses and some of the radiographers were supplementary prescribers ensuring that patients received their medicines in a timely manner.
- There was a Maggie's centre which provided a range of practical, emotional and social support.
- There was a complementary therapy team with two clinical leads; they ran a nationally recognised programme of conferences and study days. Therapies included massage, aromatherapy, acupuncture, reflexology and hypnotherapy.
- Departments in the Christie hospital were numbered and not named, some patients liked this but others found it confusing.
- Although car parking was an issue at the trust patients attending for radiotherapy had access to a car park so that they could ensure that they attended for their radiotherapy appointment on time. Most radiotherapy treatments do not take very long (10-15 minutes) but because of the volume of patients attending for treatment it was essential that they were seen promptly.

- Everyone had access to free Wi-Fi in the hospital.

Oldham and Salford.

- The radiography manager at the Oldham site had been involved in the planning and development of the building. The planning team had learned from mistakes at the Christie to design a purpose built facility with a very tranquil and calming environment. It was well laid out with a spacious waiting area, cafe and an open reception area. The changing rooms were in/out for privacy and dignity and patients went straight into the treatment area. There were foundations under the car park if more linacs were required. The unit wanted to start offering chemotherapy treatment to patients so that they wouldn't have to travel to the Christie site.
- At Oldham, radiotherapy planning for palliative treatment was done on site, those who required radical (curative) treatment had their scans done on site but the planning was done at the Christie site. Planning for palliative patients could begin on the same day that they had attended clinic. Treatment and planning for radical patients could be planned and approved remotely and information about the patient planning was shared through the radiotherapy electronic system.
- If a linac broke down patients were rescheduled and staff would work extended hours, weekends and bank holidays. Patients were always treated on the same day.
- There was a café at Oldham and a Macmillan centre for patients, including a room for patients to try on wigs. There were wigs and personal styling available for patients and the centre had an arrangement with a local branch of a national chemist for patients to receive make-up and make-overs. There was complementary therapy for patients and carers and information leaflets and benefits advice. There was a garden and charitable funding had provided cushions for the seating.
- Patients could be referred directly from the consultants' clinics at Salford to be seen on the same day for planning for lung and colorectal treatment. Patients were usually further down the treatment pathway and needed to start treatment as early as possible.
- The reception staff at Oldham rotated through the different working areas and were able to take blood which meant that patients did not have to go to the main hospital for phlebotomy services.
- At Salford the building was new and was purpose built, there was a large reception area with comfortable seating and a café, a hearing loop was available for

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those who were hard of hearing. There were a number of televisions in the waiting area and following patient feedback when a patient complained that the televisions only showed patient information, one of the televisions was being changed to show programmes for patients and relatives. Patients were then taken through to a further waiting area with a range of seating, the staff offices were in this area and patients could speak to the radiotherapy staff or nurses if they wanted information and advice. The in/out changing rooms leading straight into the treatment areas ensured patients privacy and dignity.

- The unit at Salford would treat in-patients from the hospital but they wanted to expand their service so they could take less ambulatory patients from other trusts. They were in discussion with the hospital about use of the discharge lounge to enable them to treat these patients.
- Staff said that they used translators and there were leaflets available in different languages. We saw evidence where a translator was used to consent a patient for an urgent cord compression treatment.
- The car parking at the satellite centres was free and they had dedicated car parks for their patients. There was good feedback from patients about this.

Access and flow

- The National Radiotherapy Advisory Group (NRAG) report stated that, ideally, patients should have no more than 45 minutes travel time to their treatment although, for some highly specialised services, patients may need to travel further. The uptake of radiotherapy treatment by patients is known to diminish with distance travelled by patients to reach a radiotherapy centre. The satellite centres at Oldham and Salford have provided treatment locations to the north and west of Manchester city centre to reduce travel times, though in the south of Manchester travel times exceeded 60 minutes. The trust was considering the development of a third satellite site in the south of Manchester.
- The 31 day waiting times for radiotherapy treatment were consistently at 100% for both radical and palliative treatment. The national target was 94%.
- Radiotherapy patients needed a planning appointment before they could begin treatment and most planning was carried out at the Christie site. The planning

information was transferred to the linacs electronically. Some planning for palliative treatment was carried out at the satellite sites. At Salford patients could have their masks made and their scanning done on the same day.

- At the Christie staff on the reception desks said that it was sometimes difficult to give patients the appointment times that they requested, if patients needed to be seen for review their appointment needed to coincide with the clinic times and so other patients were moved to accommodate this. Some patients having specific treatments had to be seen between 10am and 3pm and the treatment times for this were up to 40 minutes which was significantly longer than standard radiotherapy appointments. Appointments were given for five days in advance but patients were warned that these might be changed. Patients were informed of any delays in treatment on arrival. The vision was that patients would be given their entire appointment schedule in advance of their treatment. Patients attending the satellite centres received their schedule of treatment appointments in advance of their treatment including their review appointments.
- There was a booking team based in the radiotherapy department who sent out appointments to new patients. One of the consultants told us that sometimes patients did not attend for clinic because they had not received their appointments but the booking team were looking into this.
- There were scheduling issues for head and neck cancer patients who needed dental treatment before receiving radiotherapy as they needed time for any mouth wounds to heal before starting radiotherapy treatment.
- If patients did not attend for treatment the radiographers would contact them to ensure continuity of treatment. Sometimes patients were late because of traffic or because of patient transport issues but they were always seen.
- The department did not routinely collect data about waiting times for patients when they arrived in the department, though this was available on the integrated information system.
- Radiographers said that staff from the medical physics department were always available if necessary. There were designated permanent physics staff and rotational staff at the satellite sites.

Meeting people's individual needs.

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- The trust had the first dementia nurse consultant role in the country and a dementia team to support carers and carers with cancer who care for people with dementia. They had rolled out the “this is me” tool. There were three dementia champions in the service who had completed the in-house trust training and had attended a virtual reality training experience. This team were working to implement some of this training into practice.
- A case study had been completed around the “contract of care” for a patient with dementia who required radiotherapy for a head and neck cancer. In order to support the patient familiar radiotherapists were used as well as a key worker and two therapists to relax the patient. Instead of one off consent “in the moment consent” was used to support the patient. There were weekly liaison meetings with medical teams and additional support for relatives to ensure that questions were answered and that they were involved in decision making. The contract of care would be used as a framework for the complex treatment of dementia patients.
- Patients undergoing head and neck radiotherapy needed a mask that ensured that the radiotherapy they received was in exactly the right place. These patients had an individual mask made for them in the department that they wore during treatment, the masks could cause claustrophobia particularly in patients undergoing stereotactic radiotherapy as this treatment could last up to 40 minutes and the masks were three layers thick. There was a service called CALMS which supported patients during the procedure by using different techniques for relaxation. A member of staff from the service would accompany patients to their first treatment for reassurance. The technique was also used for needle anxiety, line insertions and for magnetic resonance scanning which could also be claustrophobic for some patients. There was a service called hypno-calm that consisted of six one hour hypnotherapy sessions for patients who were anxious, stressed or depressed.
- The trust had a service level agreement with a neighbouring trust to provide paediatric anaesthetists when radiotherapy needed to be given to young children, there was also access to youth workers and play specialists for children and young people.
- There was a service called HEARTS- hands on, empathy, aromas, relaxation, textures and sound- this was used by patients who were anxious, in pain or unable to sleep. It was designed for use where conventional massage techniques were inappropriate.
- If patients at the Christie needed to move to a different linac the staff moved with them to ensure continuity of treatment and care.
- Patients could request a male or female radiographers if they had a preference.
- During Ramadan the radiographers tried to accommodate the needs of these patients and would consult with the imam at the local mosque if necessary.
- The nurses in the brachytherapy unit said that they were well supported by the trust dementia nurse and that for patients with dementia and cancer they would spend extra time with families and patients to support them
- There was a feasibility study underway called e-rapid, which was a pre-trial study looking at patient symptoms to try to pick up potential problems in a timely manner. Doctors could access information that patients have left on a secure internet site and any alerts would come through to the consultant as a flagged message on their desk top. It was hoped that this would reduce admissions and would provide support to help people to deal with their symptoms.
- At Salford the patients were offered aromastix, they contained essential oils that were blended for individuals and helped with anxiety, nausea, sleep problems and smoking cessation. Patients were asked to select their preferred blend for their requirements and could use them when receiving treatment. Charitable funding had been used to purchase a fridge for storage of the oils. Patients reported that they found some benefits from the sticks.

Learning from complaints and concerns

- The lead consultant for radiotherapy was copied into all complaints received by the department and was involved in all investigations and root cause analyses of incidents and complaints. She would meet with the staff involved including consultants and would feed findings into the senior executive review meetings.
- One of the consultant oncology trainees described how she worked through a possible complaint with a

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consultant, the complaint was never formalised and came through the patient advice and liaison service (PALS), and she said that she had learned a lot from the process.

Are radiotherapy services well-led?

Good



We rated the well led domain in the radiotherapy department as good.

- There was a five year trust strategy that was supported by a quality strategy and the radiotherapy service had its own strategy. Staff we spoke with were aware of the trust strategy but not about the detail of the strategy.
- The department had the 9001:2008 ISO quality standard for radiotherapy and had gained accreditation in 1992; there was a twice yearly assessment for this international standard which was a quality management system to ensure that processes were in place.
- There had been a number of operational managers at the Salford site and they were looking forward to a period of stability following the appointment of their manager. At Oldham the manager had been in post since the unit opened and the leadership was excellent. Leadership in medical physics was strong and the physics and radiotherapy services worked well together in spite of being in different directorates.
- There was a good, open culture in the organisation and staff we spoke with said that they enjoyed working there. Patient engagement was adequate but the department were working to improve engagement using different methods. The nurses on the brachytherapy service identified that they were supported through emotionally challenging situations, however the morale of the treatment radiographers was poor. There were a range of well-being services available for staff.
- The radiotherapy manager at the Christie had been in post for five weeks at the time of the inspection. In the gap between the retirement of the previous manager and his appointment the leadership in the department had been inconsistent.
- There was a five year trust strategy that was supported by a three year quality strategy. There was a strategy for the radiotherapy department and the vision of the department was to deliver personalised radiotherapy treatment for every patient.
- The ambition of the trust was to be in the top five radiotherapy research centres in the world, particularly for technical radiotherapy however it was acknowledged that there was a way to go. The services needed to have a more seamless approach and the trust needed to bring their partners up to speed if they were to achieve this goal. An example was given about the delayed implementation of the stereotactic ablative radiotherapy (SABR).
- One of the nursing staff on the brachytherapy unit said that said that she was aware of the 2020 vision but not all the detail of the vision.
- There was a senior radiographer who was the lead for proton beam therapy and a radiographer with a lead for the pre- treatment phase of treatment was appointed during the inspection. There was also a lead from the medical physics team and a project manager.
- The trust were in the process of building a structure to house the proton beam therapy unit, this was due to become operational in August 2018. There would be three treatment areas and a fourth area for research. They had liaised with the planners of the high speed rail link (HS2) as the proposed route passed under the building. The trust worked with manufacturers of the equipment to have it built to their specification. The procurement process was described as very robust by the project manager. The trust reported to the national programme board to update them of the key issues. All the targets had been met on the action plan.
- The proton beam therapy treatment would require an additional 150 staff including 50 radiographers. Other staff would include allied health professionals, physicists, engineers and nursing staff including paediatric nurses. There was a workforce development plan which involved universities recruiting additional radiography students to address the demand in the system. The trust was working with their partners to look at retention of staff with measures which included extended notice periods. The band 5 and 6

Vision and strategy for this service

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radiographers would rotate into the service; this had helped with the recruitment of lower banded staff. Consultants at the Christie would be rotated into the proton service.

- Training will be required for the new proton beam therapy treatment and physicists will need the most intensive training as the photon treatment is very different from proton treatment. There will be placements at overseas centres for physicists, radiographers and lead clinicians. All band 5 and 6 radiographers will rotate into the proton service. It is hoped that the two proton centres will develop an in-house training package for professionals nationally and internationally.

Governance, risk management and quality measurement

- There was a robust governance structure which linked all professionals working in the radiotherapy service and developed innovative practice whilst ensuring that best practice was used and that patients were treated safely with the minimum of short and long term side effects.
- The trust radiotherapy liaison committee which was chaired by the consultant clinical oncologist looked at agenda items such as implementation of NICE guidance, new protocols and different ways of working. Information from this was fed down to the monthly divisional risk and quality meetings. These were multi-disciplinary and agenda items included risk management, complaints, serious untoward incidents and any radiotherapy related issues.
- There were also weekly operational liaison meetings for lead radiographers, lead clinicians for specialities such as brachytherapy and staff including physics staff and engineers. Agenda items for the meetings included new medicines, complaints, how to access registrars out of hours and the recent junior doctors' strike. These were done by video conferencing with the satellite sites and information from these and the quality meetings were disseminated to staff meetings for radiographers, physics and engineers. The medical physics team met weekly and some of these meetings were chaired by a band six giving the staff ownership of the meetings.
- There were monthly consultant meetings; the radiotherapy manager had suggested that he and the head of physics attend these meetings; this had been

agreed by the consultants. Agenda items included clinical trials, the junior doctors' industrial action and divisional updates and training for the specialist registrars.

- There was a medical radiation management committee and a clinical research and effectiveness committee. There was a radiotherapy clinical governance lead who was the lead clinical oncologist and a principal radiographer for governance.
- The department had the 9001:2008 ISO quality standard for radiotherapy and had gained accreditation in 1992, there was a twice yearly assessment for this international standard which was a quality management system that looked at the prescription and planning of external beam radiotherapy, the associated treatment verifications to ensure safety and accuracy, the assessment of patients undergoing radiotherapy, brachytherapy, professional and technical support and administration including internal audits.
- There was a risk register for the radiotherapy department with review dates. The highest scoring risk on the register scored 12.
- One of the superintendent radiographers was the radiotherapy quality manager and was working to bring on the quality issues for radiotherapy together onto one page of the trust intranet to make it easier to access. This was work in progress.

Leadership of service

- In the period between the retirement of the previous manager and the appointment of the new manager the management of the department had been at the 8A level and there had been a lack of overall leadership and differing management styles. Staff were unhappy and said that the team had not been visible in the department. The new manager had been in post for five weeks at the time of the inspection and was aware of the issues; he was in the process of meeting all the staff individually. There had also been a change to job descriptions for radiography staff to make them more generic, this had not helped staff morale. Senior radiographers said that it had become more difficult to recruit staff at the band 7/8A level though recruitment at the lower bands was good.
- The radiotherapy manager said that management in the department needed to become more visible and that

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there needed to be more consistency in the way annual leave and flexible working arrangements were applied and these needed to be formalised. Staff had been asked to complete comment cards and he agreed with many of the comments made, he was meeting with the unions to discuss working patterns but he wanted a flexible and responsive workforce. The portfolio of the department needed to be revamped with a review of the current workforce considering options such as consultant radiographers, additional specialist radiographers and the skill mix of staff to support the qualified staff.

- The satellite centres were managed by the radiotherapy lead and the lead consultant for radiotherapy. At an operational level the centres were managed by a superintendent radiographer and a lead clinician. Leadership at the Oldham site was excellent and the manager had been there since it opened. At Salford there had been three radiotherapy leads in the last five years, the superintendent radiographer said that staff were looking forward to a period of stability. They described the current manager as fair and consistent.
- The leadership of the medical physics team was very visible and proactive, the manager of the team worked with clinical scientists to drive change for the service.
- The nursing staff on the brachytherapy unit were part of the surgical and network directorate and said that managers were very supportive; they also commented that some of the directorates do not always understand each other. The band 6 nurse also said that she sometimes felt a little left alone.
- There was a leadership programme and workforce development for band 5's to 8A's.
- The administration team at the Christie had five managers in the last two years; their supervisor had left and had not been replaced. One of the band 8A radiographers had been managing them but they felt that their concerns had not been addressed. There had been increased sickness levels in the department.

Culture within the service

- There was a good open culture at all the sites and staff worked well with each other. In spite of issues with staffing in some areas patients were always treated courteously by all staff.

- One of the nursing staff on the brachytherapy unit described the hospital as very friendly especially the network services, they said that managers were very supportive. Another said it was a marvellous hospital to work in.
- The reception staff said that they loved working at Oldham and everyone knew everyone else. They didn't want to work anywhere else.

Public engagement

- The service was handing out patient experience questionnaires every month, 20 at the main site and 10 at each of the satellite sites. The response rate in April was 42.6% the target was 40%. The department had also started texting patients asking them to review the service and was conducting face to face interviews with patients. The department wanted to involve more radiographers in obtaining patient feedback and had appointed a band 6 radiographer to look at this. Feedback from the patient survey went to the trust board; the main issues were waiting times in clinic.
- One of the specialist radiographers had done a patient satisfaction survey for patients having radiotherapy for prostate cancer about the frequency of the review and the person who undertook the review, the feedback was very positive.
- There was a patient group looking at the interior design of the proton beam therapy unit. The trust had a residents group as the hospital is in a residential area, they were also measuring the noise from the building site of the new centre

Staff engagement

- The clinical oncology trainee we spoke with said that the trust was open to conversations with the trainees.
- Staff morale was generally good amongst the radiography staff; however the floor radiographers at the Christie had poor morale due to their workload as they had to work late every night to ensure that all patients were treated. The peak in demand came with short notice.
- Nursing staff on the brachytherapy unit said that the role could be emotionally challenging but there was counselling and alternative therapies available for staff and that managers were very supportive.

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- Activities were provided for staff including yoga, walking and a health MOT. There was a day nursery that gave priority to applications from employees.

Innovation, improvement and sustainability

- There was an extensive programme of research at the trust and with trust partners including :-
- PRECISE (Proton Research at the Christie and Institute of Cancer SciencEs) aims to develop a pipeline going from basic research, through preclinical to translational research and clinical trials, all of which are designed to improve the benefits to patients and reduce toxicity and other side-effects of radiotherapy.
- Theragnostics aims to use the large amounts of diagnostic, radiotherapy planning and outcome data which is currently available. It will exploit the data by using new developments in data mining and web technologies to extract information that can be used to predict and personalise radiotherapy treatments
- Advanced radiotherapy encompasses new developments in radiotherapy such as magnetic resonance linear accelerator and proton beam therapy to draw on strengths from the main research groups in the Christie Radiotherapy Related Research and develop new radiotherapy treatments
- The Targeted Therapy group evaluates the contribution of radiotherapy (RT)-induced immunogenic cell death to the induction of tumour-specific immune responses; determines how best to integrate RT with immunomodulatory agents to augment such responses and enhance therapeutic outcome; and investigates how combination with RT and immune modulation can be utilised to increase the efficacy and durability of anti-CD20 mAb therapy in B-cell lymphomas.
- The Developing Technologies group's research themes are measurement-guided preparation, delivery and follow-up in cancer radiation therapy.

Outstanding practice and areas for improvement

Outstanding practice

Medical care services

- The availability and accessibility of services for patients and their relatives, such as the complimentary therapies, food voucher service and were identified as outstanding practice.
- The trust was named, by the National Institute for Health Research (NIHR), as one of the best hospitals providing opportunities for patients to take part in clinical research studies. The Christie School of Oncology was established to provide undergraduate education, clinical professional and medical education and this was one of the first its kind nationally.

Surgical services

- The surgical division demonstrated an outstanding approach to treatment by the multidisciplinary cancer team who offered bespoke multi-speciality treatments, together with multi-modality therapy to patients, which improved survival rates, outcomes and quality of life for those patients.
- The trust had an outstanding programme of alternative and complimentary therapies on offer to help patients with their holistic health and wellbeing which surgical patients and people close them could access.
- The surgery directorate and wider trust displayed outstanding support and engagement for their staff. They used many different ways to engage with staff to keep them involved and included in decisions, changes and improvements within the trust. This in turn motivated and encouraged staff to improve their skills, qualifications and experience and become invested in the success of their organisation about which they were very proud.
- The surgery directorate uses the very latest state of the art surgical robots which allows surgeons to work with greater vision, precision, dexterity and control and which provides many positive outcomes and less complications for patients.

End of life services

- The SPC team used an innovative approach to their structure, which was recognised by NHS England and is now being rolled out across cancer centres throughout the country.
- GPs within Greater Manchester could access their patients' information electronically. Other GPs had to access the Christie Portal to view their patient's information.
- The service was initiating the 'goals of care' approach to help ensure that clinicians and patients truly understood each other's expectations regarding treatment and outcomes. At the time of our inspection, a small number of conversations had been trialled with patients. Clinicians told us that they found the approach ensured that conversations were easier to have and that they truly understood what their patients expected from them in their patient journey. Service leads were preparing to present this to the Cancer Vanguard for consideration for 'goals of care' being rolled out across the country.
- The team had worked to develop the 'Enhanced Supportive Care' initiative. This is a new initiative aimed at addressing more fully the needs of cancer patients. The doctor is the national lead for this initiative, which is now being rolled out by NHS England. The service received a national QIC (Quality in Care) patient care pathway award in February 2016 for this service.

Chemotherapy

- With the increase of outreach services highlighted in the five year strategy, quality was seen as paramount. To ensure standards did not fall, the Christie Quality Standard was introduced in 2014. With representatives from governance, nurses, governors, consultants and managers from the Christie and other trusts locally formed a working group to ensure consistency in standards was maintained.

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Outstanding practice and areas for improvement

- The opt-in physiotherapy lymphedema service at Salford for patients who had breast cancer was extremely good practice to address the needs of patients who were unaware if they would develop lymphedema following treatment.
- The world class research in radiotherapy and the development of the proton beam service.

Outpatients and diagnostic imaging

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Areas for improvement

Action the hospital SHOULD take to improve

Medical services

- Take appropriate actions to maintain temperatures within treatment rooms where medicines are stored.
- Take appropriate actions to improve staff appraisal rates and mandatory training compliance.

Surgical services

- Ensure that trust policy concerning the disposal and 'wasting' of controlled drugs, where the full contents of a vial are not prescribed are adhered to in theatres and recovery.
- Ensure full compliance with all aspects of the National Patient Safety Agency (NPSA) 'five steps to safer surgery' and the completion of the World Health Organisation (WHO) checklist, in particular the introduction of all staff members.
- Ensure WHO documentation audits are completed in line with recommendations.
- Ensure full compliance with trust CVC insertion infection control precautions.
- Encourage referring parties to provide more comprehensive information, background and past medical history within referrals.
- Seek to improve the legibility of handwritten surgery consent forms.
- Ensure a consistent and compliant approach to the requirements of the Mental Capacity Act 2005 regarding the two stage assessment of a patient's capacity to consent to treatment.

- Improve the temporary environment used for the pre-operative clinic, until the new facilities become available.
- Maintain the security and confidentiality of patients records and information at all times.
- Consider increasing the numbers of staff with competency based qualifications in gaining consent.
- They should continue to work towards meeting all of the recommendations of the 'Implementation of the Faculty of Pain Medicine's Core Standards for Pain Management (2015)'.

Critical care

- Ensure there is a robust process in place to monitor patients own medication on whilst in the critical care unit.
- Ensure staff are aware of safeguarding protocols in relation to female genital mutilation.
- Ensure information related to patients physical and psychological needs assessments in critical care are relayed to the staff on the ward on discharge.

End of life care

- The trust should consider implementing a way that individuals' faith needs can be met by the mortuary service.

Chemotherapy

- Improve mandatory training where there are pockets of low compliance
- Ensure rooms storing medicines are below 25°C.

Outstanding practice and areas for improvement

- Review the attendance at divisional governance meetings to ensure staff attendance is adequate.
- Ensure that where required (sluice room on the ground floor of the Palatine Centre) is secured and that chlorine based cleaning products and hand sanitizers are stored securely at all times.
- The trust should review the management structure and the skill mix in the radiography department and to consider roles for radiographers that include routine treatment delivery and review for patients and allows specialist registrars and consultants to treat more complex.

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- Review the staffing level requirements for treatment radiographers.
- The trust should ensure that all radiographers who have contact with children and young people are trained to level three in safeguarding of children and young people. patients.