East and North Hertfordshire NHS Trust

Mount Vernon Cancer Centre

Quality Report

Mount Vernon Hospital
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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	Requires improvement
Medical care	Inadequate
End of life care	Requires improvement
Outpatients and diagnostic imaging	Good
Chemotherapy	Requires improvement
Radiotherapy	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Mount Vernon Cancer Centre (MVCC) is part of East and North Herts NHS Trust and provides a specialist non-surgical cancer service. It is situated in Hillingdon, Middlesex on a large site owned by Hillingdon NHS Trust and is some 33 miles from East and North Herts Trust's main hospital in Stevenage.

It serves a wide area of 2 million people across Hertfordshire, Bedfordshire, Northwest London and parts of the Thames Valley.

The cancer centre has never been inspected by the Care Quality Commission before and was inspected on this occasion as a specialist stand-alone unit as part of the comprehensive inspection of East and North Herts NHS Trust.

We inspected five core services, chemotherapy, radiotherapy, medicine, outpatients and end of life care. Radiotherapy and outpatients were rated good. However, end of life care and chemotherapy required improvement. Medicine was rated as inadequate.

Overall, we rated MVCC as requiring improvement on two of the five key questions which we always rate. The areas that required improvement were responsiveness and well led. Safety was rated as inadequate overall.

Overall caring and effectiveness were good. In chemotherapy, caring was rated as outstanding, where it was evident staff were encouraging and supportive and went the extra mile to ensure that patients were cared for in the best possible way.

Our key findings were as follows:

- The environment had not been always been well maintained and there were areas of risks that had not been addressed by the service. These concerns were brought to the attention of senior staff during the inspection.
- Infection rates were low. There had been no reported incidents of MRSA or Clostridium Difficile (C.Difficle) in the six months prior to our inspection. Clinical waste was disposed of safely. This included chemotherapy waste.
- There was a low recording of incidents by staff in some areas.
- Urgent transfers out of the hospital were not reported on the trust wide incident reporting system. They were recorded in a diary type format, but this lacked detail with regards to the reason for transfer and patient outcomes. There was no trend analysis or evidence of learning.
- There was no process in place to follow up these patients so the service was not updated on whether the patients' cancer treatment had been maintained. Therefore, the trust was unsighted on this risk and no actions had been taken to address this concern.
- There was limited completion of observation and fluid balance, especially for patients receiving intravenous therapy or fluid irrigation. In patient nursing assessments were often incomplete and actions were not reviewed with the patient.
- The wards duplicated documents for recording and administering blood transfusions. On observation we found that standards of hand-washing did not meet the infection control national guidance standards.
- We found that there were sufficient doctors and registered nurses on duty, and nursing numbers were monitored daily. Patients who were deteriorating were seen by medical staff and care reassessed promptly.
- Most staff had good access to training and appraisal systems, although some reported that travelling to the trust's main site in Stevenage for training, was difficult.
- There was evidence of local clinical audits and action required at ward level. Intentional rounds were carried out to assess patients' pain and symptom relief.

Summary of findings

- There was a daily multidisciplinary (MDT) handover and a weekly in-depth MDT patient review. We found that there was a strong culture of multidisciplinary working between nurses, specialist nurses, doctors, allied health professionals and social workers. The service was covered by a consultant seven days per week and interventions were carried out at weekends.
- Patients received compassionate care, were treated with dignity, respect and reported they felt safe. Both patients and their relatives were positive about their experiences of care and kindness offered to them. We observed a supportive volunteer system adding strength to the clinical teams' positive approach. Patients told us that they were involved in decisions about their care and treatments and were given appropriate information
- Staff had limited awareness of the trust's vision and values. The reported culture amongst some of the nursing staff was a resistance to change and some staff members not taking the responsibility that their grade denoted. New nursing leadership was beginning to address this.
- There was a process in place to obtain rapid treatment for patients who were suspected of having neutropenic sepsis. There was a procedure in place to minimise chemotherapy being given via the incorrect route. Only 30% of patients who were suspected of having neutropenic sepsis received antibiotics within two hours of admission. However, not all these patient were admitted to MVCC.
- The hospital was meeting the 31 day target for treating patients who required chemotherapy and radiotherapy for most tumour types.
- All the consultants specialised in treating one or two tumour sites only.
- There was almost always long queues in the outpatients department for patients to be checked in, although patients who were nervous, for example, if they were needle phobic, were seen and reassured as soon as possible. There were always long waits for treatment, whether the patient chose to have a one stop option or blood tests on one day and treatment the next. Patients who required daily treatment, but did not need an in-patient bed, were able to stay in the hospital's on-site hostel.
- Patients often needed to go outside the main building to access other services. Often their individual needs were not always met with regards to keeping warm and dry.
- Patients who required specialised treatment by a plastic surgeon for extravasation, needed to be transferred off site.
- The service to insert PICC lines operated three days per week. This meant patients sometimes had their first treatment without the PICC line in situ.
- Although each division within the hospital had local objectives and there were objectives for the cancer centre, there was no principal cancer strategy, nor was there a director with sole responsibility for cancer. There was no strategic oversight of the chemotherapy service.
- All the staff we spoke with were proud to work for the Cancer Centre and would want their friends and family to be treated there should the need arise.
- The radiotherapy service had a strong reputation nationally as a major contributor to clinical trials. There was clear evidence of both staff and patient engagement in service provision and development. The trust had a replacement for the Liverpool Care Pathway (LCP) called the Individual Care Plan for the dying person (ICP).
- The end of life service did not collect information of the percentage of people achieved discharge to their preferred place within 24 hours. Without this information, we were unable to monitor if the service was honouring peoples' wishes and if the trust needed to make any improvement on this.
- Staff had limited awareness of the trust's vision and values. The leadership team could articulate their plans for the future, but did not have a clearly defined cancer strategy in place.

We saw several areas of outstanding practice including:

- The radiotherapy service provides IMRT (Intensity Modulated Radiotherapy) to a higher percentage of patients than the England average. The service provided a good range in IGRT (Image Guided Radiotherapy). Together these are indicators of a high quality radiotherapy service.
- The radiotherapy service had a strong reputation nationally as a major contributor to clinical trials.
- The radiotherapy service was accredited to the ISO 9001 quality standard.

Summary of findings

- The cancer centre is one of the top ten centres in the country for research and innovation.
- Care shown to patients undergoing chemotherapy was outstanding.
- Effective multidisciplinary working was evident throughout all departments.
- All staff were proud to work for MVCC and many described it as a special place to work.

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

Action the hospital MUST take to improve:

- Ensure that patients who require urgent transfer have their needs met to ensure their safety and that there is an effective process in place to handover continuing treatment.
- Ensure there is oversight and monitoring of all transfers.

Action the trust SHOULD take to improve:

- Consideration given to patients' needs are responded to when they are transported outside the building.
- Consideration should be given towards using one system for recording and administrating blood transfusions. Standards of hand-washing did not meet the infection control national guidance standards.
- Consider that urgent transfers out of the hospital are recorded on the trust's incident reporting system, so that there is an oversight for the reasons for transfer.
- Consider ways of resolving long waits in outpatients and for chemotherapy.
- Consideration should be given to unwell patients having to queue for their outpatient appointments.
- Ensure that all staff are aware of their responsibilities with regards to DoLs and MCA.
- Consider a more effective way of ensuring the environment in Michael Sobell House (MSH) is clean and safe.
- Consider collecting information of the percentage of people who achieved dying in their preferred location.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Inadequate 	Overall we found the two inpatient medical wards 10 and 11 were inadequate, although the care given was caring. Urgent transfers out of the hospital were not reported on the trust wide incident reporting system. They were recorded in a diary type format, but this lacked detail with regards to the reason for transfer and patient outcomes. There was no trend analysis or evidence of learning. There was no process in place to follow up these patients so the service was not updated on whether the patients' cancer treatment had been maintained. Therefore, the trust was unsighted on this risk and no actions had been taken to address this concern. Nursing assessments were incomplete and actions were not reviewed with the patient. There was limited completion of observation and fluid balance, especially for patients receiving intravenous therapy or fluid irrigation. The wards duplicated documents for recording and administering blood transfusions. On observation we found that standards of hand-washing did not meet the infection control national guidance standards. We found that there were sufficient doctors and registered nurses on duty, and nursing numbers were monitored daily. Patients who were deteriorating were seen by medical staff and care reassessed promptly. Staff had access to training and appraisal systems. There was evidence of local clinical audits and action required at ward level. Intentional rounds were carried out to assess pain and efficacy of symptom relief. There was a daily MDT handover and a weekly in-depth MDT patient review. The service was covered by a consultant seven days per week and interventions were carried out at weekends. There was limited awareness of Mental Capacity Assessments and DOLS.

Summary of findings

Patients received compassionate care, were treated with dignity, respect and reported they felt safe. Both patients and their relatives were positive about their experiences of care and kindness offered to them.
Patients told us they were involved in decisions about their care and treatment and were given the right amount of information to support their decision making. Due to limited space at the bedside, personal care and treatment discussions with patients could be clearly overheard by other patients and their relatives. Emotional support was provided by staff in their interactions with patients. Most patients were positive about their experience. Confidentiality, when discussing issues on the ward with patients, was compromised due to the ward layout. There was limited access to services for patients being discharged. Nursing staff had been nominated for an excellence award for the care of a patient with a learning disability.
Staff had limited awareness of the trust's vision and values. The reported culture amongst some of the nursing staff was a resistance to change and some staff members not taking the responsibility that their grade denoted. New nursing leadership was beginning to address this.

End of life care

Requires improvement

We found the service to be caring and responsive but it was rated as inadequate for safety and required improvement in effectiveness and to be judged well led.
The fabric of the building in Michael Sobell House was old, tired and dirty. We saw a number of maintenance issues of concern that had not been identified or addressed and were not on the service risk register. We saw that cleaning standards were poor.
When things went wrong, reviews and investigations were not always thorough. The managers did not always identify or make the necessary improvements. Relevant managers had reviewed incidents, but there was limited

evidence that any action had been taken to reduce the risks. It was clear that no manager's action or comments were documented with regards to some incidents.
We saw that staff had overlooked patients' capacity to make a decision on occasions. Staff had used pressure sensor equipment to reduce the risk of a patients falling. We did not see any assessment of a patient's capacity about the use of the equipment with the patients, or those close to them documented in the patients' notes.
Whilst the he trust participated in the National Care of the Dying Audit (NCDA) 2013/14, data supplied did not include Michael Sobel House. The trust had a replacement for the Liverpool Care Pathway (LCP), the Individual Care Plan for the dying person (ICP). The LCP was a UK care pathway that covering palliative care options for patients in the final days or hours of life. It provided guidance to help doctors and nurses provide quality end-of-life care. The Department of Health phased it out in 2013 after an independent review. The ICP provide guidance for staff to ensure that people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. The SPCT monitored the implementation of the IPC. The service did not have the all the processes and information to manage current and future performance and did not collect information of the percentage of people who achieved dying in their preferred location. In addition, the service did not collect information of the percentage of people achieved discharge to their preferred place within 24 hours. Without this information, we were unable to monitor if the service was honouring peoples' wishes and if the trust needed to make any improvement on this.

Outpatients and diagnostic imaging	**Good**		There was a clear process for reporting and investigating incidents and learning from incidents took place.

Summary of findings

The cleanliness and hygiene in the departments was within acceptable standards. Personal protective equipment was readily available for staff and was disposed of appropriately after use.

Staff were aware of their role in safeguarding, a reporting process was in place and staff knew how to escalate concerns

Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal.

Staff obtained written and verbal consent to care and treatment which was in line with legislation and guidance.

There were always long waits to both register and be seen in the department. To register, the patients had to queue in a corridor that was a general thoroughfare. There were no comfortable chairs, or chairs to suit people who were less mobile.

Patients received a caring service. Patients were treated with dignity and staff were kind, respectful and supportive. Staff gave clear explanations of treatments and most patients were positive about the care they received.

Patients and their relatives were positive about their experiences of care and kindness offered to them. Patients told us that they were involved in decisions about their care and treatments and were given appropriate information.

The Cancer Management team were recognised by everyone we spoke to as being effective. This was highly valued by members of the clinical team. The executive team were less visible in non-clinical areas. There was a positive culture; staff felt engaged in (and part of) the Mount Vernon Cancer Centre.

There were strong governance systems in place. Review of information and audit supported management actions. Regular Quality Improvement Team meetings were held. We saw evidence of their impact.

There was clear evidence of both staff and patient engagement in service provision and development

Summary of findings

Chemotherapy

Requires improvement

Overall the service offered within chemotherapy required improvement, although the service was outstanding for caring.

Although the hospital gathered patient information such as hospital acquired infections and reviewed these through its clinical governance processes, there was no oversight of urgent transfers.

There was a process in place to obtain rapid treatment for patients who were suspected of having neutropenic sepsis via an acute oncology service. Only 30% of patients who were suspected of having neutropenic sepsis received antibiotics within two hours of admission. However, not all these patients were seen at MVCC, but at neighbouring trusts. There was an effective procedure in place to minimise chemotherapy being given via the incorrect route

Staff understood their responsibilities to raise concerns, record and report safety incidents, and near misses, and to report them internally and externally, although learning from incidents and complaints was limited.

All areas appeared clean, the units were bright. However, the building at Mount Vernon was old and required updating and refurbishment.

There were almost always long queues in the outpatients department at Mount Vernon for patients to be checked in for their treatment, although patients who were nervous, for example, if they were needle phobic, were seen and reassured as soon as possible. There were always long waits for treatment, whether the patient chose to have a one stop option, or blood tests on one day and treatment the next.

Patients who required daily treatment, but did not need an in-patient bed, were able to stay in the hospital's on-site hostel.

Patients often needed to go outside the main building to access other services. Often their individual needs were not always met with regards to keeping warm and dry.

Patients who required specialised treatment by a plastic surgeon for extravasation, needed to be

Summary of findings

transferred off site. The service to insert PICC lines, operated three days per week. This meant patients sometimes had their first treatment via a cannula, without the PICC line in situ.
Infection rates were low. There had been no reported incidents of MRSA or C Diff. in the two years prior to our inspection. Clinical waste was disposed of safely. This included chemotherapy waste. There were arrangements in place for managing medicines, including chemotherapy and radioactive substances to keep people safe.
Generally the hospital was adequately staffed. Mandatory training rates for all staff were at 87% against a hospital target of 90%.
The hospital took part in local, the trust's and national audit programmes. Audits, undertaken of patients' records each month were audited against compliance with assessment tools and care bundles.
The hospital was meeting the 31 day target for treating patients who required chemotherapy and radiotherapy for most tumour types.
All the consultants specialised in treating one or two tumour sites only. We found that there was a strong culture of multidisciplinary working between nurses, specialist nurses, doctors, allied health professionals and social workers.
None of the staff we spoke with had received training about the Mental Capacity Act 2005 (MCA).
Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Patients and relatives were well supported and were given as much or as little information as they wanted. Staff often went out of their way to ensure patient care went beyond their remit as healthcare professionals.
There were links to access special care for patients with a learning disability. Staff had not had any training to care for patients living with dementia.
The ratio of compliments far exceeded the complaints. However, we found that not all complaints, particularly verbal complaints were recorded.

Summary of findings

Although each division within the hospital had local objectives, there was no principal cancer strategy, nor was there a director with sole responsibility for cancer. There was no strategic oversight of the chemotherapy service. All staff were aware of the trust's vision. There was a plan in place to be autonomous from Hillingdon NHS Trust. All the medical staff had an afternoon of management time written into their contracts.
All the staff we spoke with were proud to work for the Cancer Centre and would want their friends and family to be treated there should the need arise.

Radiotherapy

Good

Overall the service offered within radiotherapy was good.
There was a good culture of safety. Incidents were reported, investigated and lessons learnt.
The radiotherapy service had a good range of clinical equipment to meet the latest standards of care.
The radiotherapy service provides IMRT (Intensity Modulated Radiotherapy and IGRT (Image Guided Radiotherapy) to a high standard.
The radiotherapy service was a major contributor to national clinical trials.
Staff were well trained. There was a robust system for ensuring and measuring competencies. There was a strong multidisciplinary team work ethos. There was an integrated electronic system ensuring staff could access clinical information in all places where it was required.
We saw staff were very caring. We observed a supportive volunteer system adding strength to the clinical team's positive approach. The Friends and Family Test results for cancer services were 98.9%. Patients, and where appropriate, their relatives, were involved in their care.
Some parts of the hospital were not in a good state of repair, such as the nuclear medicine unit. The unit was cold in the winter and let draughts through the windows.

Summary of findings

The service performed well against the 31 day waiting time standard for subsequent radiotherapy.
There was a strong leadership team in the radiotherapy service. The management team were recognised by everyone we spoke to as being highly effective. This was valued by members of the clinical team.
The leadership team could articulate their plans for the future, but did not have this as a written strategy agreed by the trust. We were not able to see a written cancer plan for the Mount Vernon Cancer Centre or the radiotherapy service.
There were strong governance systems in place. Review of information and audit supported management actions. Regular Quality Improvement Team meetings were held. We saw evidence of their impact.
There was clear evidence of both staff and patient engagement in service provision and development.
The service was highly innovative and demonstrated many areas of good practice.

Mount Vernon Cancer Centre

Detailed findings

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

Detailed findings

Contents

Background to Mount Vernon Cancer Centre

Mount Vernon Cancer Centre (MVCC) is part of East and North Herts NHS Trust and provides a specialist non-surgical cancer service. It is situated in Hillingdon, Middlesex on a large site owned by Hillingdon NHS Trust and is some 33 miles from East and North Herts Trust's main hospital in Stevenage.

The hospital facilities include:

- A chemotherapy suite, in two separate locations within the hospital, which treats around 150 patients a week using 11 chairs and 2 beds.
- The Lister Hospital, Stevenage: an 18 chair chemotherapy suite which treats 220 patients a week.
- Two inpatient wards, which have 47 beds between them.
- Iodine suite treating 120 patients per year.
- The Paul Strickland Scanner Centre providing comprehensive scanning services to the NHS and private health sectors for the diagnosis, treatment, monitoring and research of cancer and other serious diseases, using Positron Tomography (PET) Computerised Axial Tomography (CT) and Magnetic Resonance Imaging (MRI) scanners.
- A comprehensive radiotherapy service from the point of clinical referral to the first follow-up appointment.
- Nine linear accelerators providing radiotherapy treatments, including CyberKnife and TrueBeam.
- Nuclear Medicine Imaging and an outpatient therapy service.
- An outpatients department which saw about 90,000 patients a year.
- The Lynda Jackson Macmillan Centre: Provides support and information to people affected by cancer. The centre supports patients and families with all aspects of the disease from diagnosis, through treatment and beyond.
- The Michael Sobell House palliative care unit: Michael Sobell Hospice provides care, comfort and support for local people facing life limiting illnesses. It is situated within the Mount Vernon Hospital site. Services provided include: inpatient unit, day centre, patient and family support and rehabilitation.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Tim Cooper, Head of Hospital Inspections, Care Quality Commission

The team included CQC inspectors and a variety of specialists: including a consultant oncologist, chemotherapy nurses, and a specialist in radiotherapy services.

Detailed findings

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 of people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we held about Mount Vernon Cancer Centre and asked other organisations to share what they knew about the hospitals. These included the Trust Development Authority, Clinical Commissioning Groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges, local MP's, and the local Healthwatch.

We held listening events in Stevenage and Welwyn Garden City before the inspection, where people shared their views and experiences of services provided by East and North Herts NHS Trust. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection of Mount Vernon Cancer Centre during 20 – 23 October 2015.

We held focus groups with a range of staff during our inspection. The focus groups included nurses, junior doctors, consultants, health care assistants, allied health professionals, ancillary staff and clerical staff. We also spoke with staff individually.

We talked with patients and staff from all the departments, ward areas, Michael Sobell House, The Lynda Jackson Memorial Centre, and outpatient services.

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 Mount Vernon Cancer Centre

Facts and data about Mount Vernon Cancer Centre

The trust's main catchment is a mixture of urban and rural areas in close proximity to London. The population is generally healthy and affluent compared to England averages, although there are some pockets of deprivation – most notably in Stevenage, Hatfield, Welwyn Garden City and Cheshunt. Over the past ten years, rates of death from all causes, early deaths from cancer and early deaths from heart disease and stroke have all improved and are generally similar to, or better than, the England average.

The hospital employs 532 whole time equivalent (WTE) staff and has a vacancy rate of 7%.

The inpatient bed occupancy at MVCC was around 67%.

There is a management team for the cancer centre which includes a clinical director, senior manager and lead nurse.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Medical care

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

Information about the service

Mount Vernon Cancer Centre has two inpatient wards in the oldest part of the building. The one male ward, ward 10, has 24 beds including 1 step up bed and three side rooms. The one female ward, ward 11, has 21 beds including 1 step up and two iodine rooms and 7 side rooms. The wards care for patients who require inpatient treatment because they are unwell during or following their radiotherapy or chemotherapy treatment. In addition, some patients were admitted for their treatment if it was particularly arduous, or the patient was frail. Some patients received end of life care on the wards.

The female ward included a two bed unit for patients who had undergone iodine therapy and were required to be isolated for a short period of time. One bed on each ward had been set aside as a "step up" bed for patients requiring a higher level of care.

We spoke with fifteen patients and relatives, four doctors, seven nursing staff, a social worker and one administrator, during our visit. We observed interactions between patients and staff, considered the environment and looked at thirteen care records.

Summary of findings

Overall we found the two inpatient medical wards 10 and 11 were inadequate, although the staff were caring.

Urgent transfers out of the hospital were not reported on the trust wide incident reporting system. They were recorded in a diary type format, but this lacked detail with regards to the reason for transfer and patient outcomes. There was no trend analysis or evidence of learning. There was an informal process only in place to follow up these patients, so the service was not always updated on whether the patients' cancer treatment had been maintained. The trust told us that in response to the concerns raised during the inspection, oversight had been improved through the introduction of a transfer follow up book which allowed updates to be recorded and monitored. Therefore, the trust was unsighted on this risk and no actions had been taken to address this concern. However, since the inspection, the trust told us that they had introduced a transfer follow up book.

Nursing assessments were incomplete and actions were not reviewed with the patient. There was limited completion of observation and fluid balance, especially for patients receiving intravenous therapy or fluid irrigation.

The wards duplicated documents for recording and administrating blood transfusions. However, since the

Medical care

inspection the trust told us that the MVCC medicine chart has been reviewed and the blood transfusion section has been removed. This new process was being implemented during February 2016.

On observation we found that standards of hand-washing did not meet the infection control national guidance standards, although internal audits indicated that there was compliance.

Patients often had to wait for their take home medicines. Medicines were stored safely.

We found that there were sufficient doctors and registered nurses on duty, and nursing numbers were monitored daily. Patients who were deteriorating were seen by medical staff and care reassessed promptly.

Staff had access to training and appraisal systems. There was evidence of local clinical audits and action required at ward level. Intentional rounds were carried out to assess pain and efficacy of symptom relief. There were audits of pain control.

There was a daily MDT handover and a weekly in-depth MDT patient review. The service was covered by a consultant seven days per week and interventions were carried out at weekends. There was limited awareness of Mental Capacity Assessments and DOLS.

Patients received compassionate care, were treated with dignity and respect and reported they felt safe. Both patients and their relatives were positive about their experiences of care and kindness offered to them.

Patients told us they were involved in decisions about their care and treatment and were given the right amount of information to support their decision making. Due to limited space at the bedside, personal care and treatment discussions with patients could be clearly overheard by other patients and their relatives.

Emotional support was provided by staff in their interactions with patients. Most patients were positive about their experience. There were allocated social workers for the wards, who supported discharge. Discharge arrangements were managed by the ward and were mostly planned one day ahead.

Nursing staff had been nominated for an excellence award for the care of a patient with a learning disability.

Staff had limited awareness of the trust's vision and values. It was reported to us that some members of staff were resistant to change. In addition, some staff members were reported not taking the responsibility that their grade denoted. New nursing leadership was beginning to address this.

Medical care

Are medical care services safe?

Inadequate

The safety of the inpatient wards was inadequate.

Urgent transfers out of the hospital were not reported on the trust wide incident reporting system. They were recorded in a diary type format, but this lacked detail with regards to the reason for transfer and patient outcomes. There was no trend analysis or evidence of learning.

There was no process in place to follow up these patients so the service was not updated on whether the patients' cancer treatment had been maintained. Therefore, the trust was unsighted on this risk and no actions had been taken to address this concern.

There was limited completion of observation charts, particularly fluid balance, especially for patients receiving intravenous therapy or fluid irrigation. Nursing assessments were incomplete and actions were not always reviewed with the patient.

On observation we found that standards of hand-washing did not meet the infection control national guidance standards. The wards duplicated documents for recording and administrating blood transfusions.

Medicines were stored safely.

There was effective multidisciplinary working and systems in place to recognise and support deteriorating patients.

The wards were adequately staffed. There were good systems in place for multidisciplinary working. Training, including safeguarding was up to date and was compliant with the trust's targets.

Incidents

- There were processes in place for reporting of incidents. From September 2014 – September 2015, 581 incidents were reported for MVCC. The vast majority, 541, had been categorised as low or very low. Two were rated as serious, one of which related to medical care, but this had been thoroughly investigated and lessons had been learnt. Other incidents we saw had been investigated thoroughly.
- The hospital reported that there had been no incidences of a never event, in the reporting period July 2014 to June 2015. A never event is a serious incident that is 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 opportunities for staff to receive feedback and lessons learnt via staff meetings, MDT meetings, staff room notice boards and an online 'knowledge hub.' However, some staff were unclear as to how incidents were reported and processed. There was some evidence incidents were fed back to staff. This was achieved through staff meetings; MDTs staff room notice boards and an on line Knowledge Centre, although one nurse leader described an under reporting culture.
- Medical staff understood how to report an incident, however they tended to report it to nursing staff who would remedy concerns; an example was the omission of a drug.
- The senior staff told us there was a ward risk register. We did ask the trust for this, but it was unavailable.
- Patients were transferred out of the hospital by emergency (999) ambulance if they developed conditions or complications whilst they were receiving treatment for their cancer, for example bleeding or cardiac problems. This happened on average up to twice per week. However, these were not recorded as incidents on the hospital reporting system. They were recorded locally in a diary type format, but this lacked detail with regards to the reason for transfer and patient outcomes. There was no trend analysis or evidence of learning. Therefore it was difficult to ascertain the extent of any patient safety implications. The trust told us that in response to the concerns raised during the inspection, oversight had been improved through the introduction of a transfer follow up book which allowed updates to be recorded and monitored.
- Mortality and morbidity meetings were undertaken quarterly.
- There were weekly governance seminars which were attended by the MDT.
- Alerts received externally requiring action, for example alerts from the National Reporting and Learning System

(NRLS) were circulated to all the trust leaders, with a date for feedback or actions. These were effectively followed up. This meant appropriate action was taken with regards to any national alerts.

Safety thermometer

- The NHS Safety Thermometer audit provided a 'temperature check' on levels of harm and enabled the measurement of 'harm free care'. Harm free care was defined by the absence of pressure ulcers, harm from a fall, urine infection (in patients with a catheter) and new venous thromboembolism (VTE). Ward 10 audit data showed five harms in the period of February to October 2015. Ward 11 indicated six harms in the same time frame. Two of these harms related to one patient with an indwelling urinary catheter that developed two urinary tract infections. However, the data provided by the trust did not always detail what type of harm had occurred, or evidence of the changes made as a result. There had been no hospital acquired pressure ulcers for patients on wards 10 and 11 for more than 1000 days. At the time of this inspection ward 10 had had 1,067 pressure ulcer free days and ward 11 had 1,157 Pressure ulcer free days.

Cleanliness, infection control and hygiene

- The ward environment, although old, was clean. We saw that green "I am clean" stickers were in use to denote when an item of equipment had been cleaned and was ready for use. However we saw that the dates on some stickers were over a month old and the equipment was not covered. This meant that equipment, which had been left exposed, may not have always been clean.
- The most recent hand hygiene audit (June 2015) showed that Ward 10 staff were 86% compliant and Ward 11 100% compliant with effective handwashing. However, we observed that staff were not always washing their hands in line with the World Health Organisation (WHO) guidance, "Five moments for hand hygiene."
- Adequate supplies of personal protective equipment (PPE), for example, gloves and aprons, were available on the wards and we observed staff using these when delivering care. We noted that all staff adhered to the trust's "bare below the elbows" policy.
- Side rooms were available to patients who required isolation if they had an infection or were immuno-compromised. We saw that correct procedures were followed to either protect the immuno-compromised patient, or to protect staff and other patients from an infection.
- We observed that sharps management complied with Health and Safety (Sharps instruments in Healthcare) Regulations 2013. Bins were locked, were not overfull and were dated and signed.
- We observed a patient arriving on ward for blood transfusion and needing a blood test. They were placed in chair of a bed space occupied by another patient who was temporarily away from the ward for treatment. The blood test was taken with no acknowledgement of the need for privacy. The relatives were unable to sit with the patient and stood awkwardly across the other side of the ward. The patient whose bed space was being utilised returned from their treatment and was put in adjacent bed space until the intervention was completed on the patient requiring the blood test. This was an infection control risk.
- Clinical waste was kept, ready for collection, in an outside compound. This was locked as were all the large waste bins that we saw.
- Disposable curtains were in use between bed spaces and were labelled with the date they were installed, indicating that they had been changed in the last five months.
- The patient-led assessment of the environment (PLACE) survey score for the hospital was 98% for cleanliness in 2015. We saw a specific action plan following the PLACE audit to ensure improvements were made

Environment and equipment

- Both wards shared resuscitation equipment which was stored on a resuscitation trolley, readily accessible for both wards. Daily checks were carried out and recorded against a check list, which had no omissions
- We saw that all Electrical Medical Equipment (EME) had registration (asset) labels and it was maintained and serviced in accordance with manufacturer's recommendations. Portable Appliance Testing (PAT) labels were attached to equipment showing they had been tested and were safe to use. The labels were observed to be in date.

Medicines

Medical care

- There were arrangements in place for managing medicines, including chemotherapy and radioactive substances to keep people safe. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.
- There was a pharmacist who had a specialist qualification in oncology. We checked a range of medicines on wards 10 and 11 and found that they were stored safely. This included Controlled Drugs (CDs) and chemotherapy. If medicines were not given, there was a reason for this annotated on the patient's drug chart.
- Fridge temperatures were checked and recorded and were within the correct range to store medicines correctly. There was a process in place to follow if the temperature was above an acceptable range. The fridges were locked.
- CDs were stored in lockable wall units. We saw that they were reconciled correctly.
- Nurses undertook an annual medicines and chemotherapy administration competency. This was repeated and extra support was given if a medication error was made. There were two medication incidents reported by Ward 10 and six by Ward 11, in June 2015. We saw some evidence that lessons had been learnt, particularly with regards to the staff who were involved.
- We observed a medicines round and saw the nurse checking the identification of each patient prior to administrating the medicines. However, we observed that the nurse undertaking the medicines round was constantly interrupted. This meant there was a risk of losing concentration and making an error.
- Pharmacy staff members attended the ward every day to check top up and stock levels In addition, the pharmacy technician carried out a Controlled Drug check and medicines storage check with the lead nurses every three months.

Records

- Patient's records, apart from chemotherapy treatment, were paper. We looked at nine sets of patients' records and found all of them to be incomplete with regards to nurse assessment and actions, intentional rounds and diet charts.
- Fluid balance particularly was poorly recorded, we saw that seven out of nine records were incomplete, especially when patients were receiving intravenous therapy, fluid irrigation and output monitoring.
- Staff mostly signed and dated their entries in the patients' records. Medical staff used, in addition to signing, stamps with their registration number and name.
- Hard copy medical records were stored securely in a locked room between the two wards whilst the patents were receiving treatment.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and adhered to safeguarding policies and procedures.
- Safeguarding training was mandatory. The safeguarding team was based at The Lister Hospital; staff reported that they were supportive. Safeguarding contacts and flow charts were seen in the ward offices.
- There were systems in place to make safeguarding referrals if staff had concerns about a vulnerable adult. The staff we spoke with talked confidently about the types of concerns they would look for and what action they would take.

Mandatory training

- All staff on the medical wards were expected to attend mandatory training which covered safeguarding adults, safeguarding children, moving and handling, infection prevention, equality and diversity, information governance, health and safety and fire.
- Staff had access to mandatory training. As at June 2015 both wards staff were 92% compliant with mandatory training, against a trust target of 90%.
- A senior nurse reported that staff had good access to training, both electronic and face to face. In addition training was given, for example chemotherapy administration, 'on the job,' in the clinical areas.
- All the senior nursing staff (band 6 and up) were up to date with their immediate life support (ILS) course that was attended annually.
- End of life care training was included in the trust's mandatory training.

Assessing and responding to patient risk

Medical care

- Patients were risk assessed using nationally validated tools, for example Waterlow scoring**,** cannulation assessment and the Anderson tool for pressure ulcers. Symbols were seen placed above the bed-head to denote an individual's risk of falls.
- National early warning scores systems (NEWS) was used to identify patients whose conditions were at risk of deteriorating. Evidence of night staff escalating an unwell patient appropriately to the medical team was seen in patient's notes and on the NEWS documentation.
- There was a system in place to support the deteriorating patient.
- In 2013. a medical notes audit of 28 high dependency (HDU) admissions to MVCC over seven months highlighted several concerns with patient management, these included:
- Lack of medical review (60%),
- Anaesthetists not informed of admission (30%),
- Resuscitation status not documented (22%),
- Ceiling of care not documented (50%), and
- Plans for escalation and transfer for Level 3 not documented (70%).
- Following this an operational policy for the management of these patients was developed. This was provided to us in a draft format, dated October 2015.
- However an independent audit carried out in August 2015 showed a significant improvement since 2013.Ceiling of care not documented in only 26% (50% in 2013)Plans for escalation documented in 74% (30% in 2013)Lack of medical review in 37% (60% in 2013)Resuscitation status documented in 93% of patients (78% in 2013)
- After discussion at the senior management board at MVCC the decision was take, at that time, to rename the HDU beds to 'step up' beds and have clear admission criteria. 'Step up' beds were for patients requiring closer monitoring or a higher level of care. However, this did not stretch to level two (one or more organ requiring support,) or level three (critical) care. There was one 'step up' bed per ward. There was a senior nurse who assessed and could give first line treatment if a patient was identified as deteriorating. In addition there was support from an on call anaesthetist. All patients that required higher level two or three care were transferred out of the hospital immediately.
- There was documentation in place developed to support the 'step up' patients. The trust provided a copy of the MVCC 'step up' admission form. This included prompts to ensure the consultants reviews took place, any ceiling of treatment decisions and early warning scores that triggered the admission. However, when we checked four sets of records, we found that these were not completed thoroughly; one part of the form which described decision processes was never completed.
- There were also pathways for transfer of emergency and urgent patients at MVCC including key contacts related to specific specialities. It stated that if the patient had a condition that required urgent treatment, for example, bleeding, a blue light ambulance must be called and patient was transferred to other neighbouring trusts for ongoing treatment. Up to two patients were transferred urgently every week. These were all recorded informally and were not reported via the trust's incident reporting system. There was no process in place to follow up these patients so the service was not updated on how the patients' cancer treatment been maintained. Therefore, the trust were unsighted on this risk and no actions had been taken to address this concern. The trust told us that in response to the concerns raised during the inspection, oversight had been improved through the introduction of a transfer follow up book which allowed updates to be recorded and monitored.
- We observed a patient receiving a blood transfusion. A blood tracking care plan was not carried out. Blood for transfusions was delivered from Hillingdon Hospital NHS Trust and nursing staff carried out a complete check using their documentation. However, the blood had been prescribed on the new Lister Hospital medicines chart which had been introduced two weeks prior to our inspection. There was duplication of blood tracking stickers and recording of data. Since the inspection the trust told us that the MVCC medicine chart has been reviewed and the blood transfusion section has been removed. This new process was being implemented during February 2016.
- There was a two bedded iodine treatment suite on Ward 11. There were protocols in place to protect the patients and the staff from this radioactive substance. The patients were isolated until their levels of radiation had lowered to a level that was not harmful to others.

Nursing staffing

Medical care

- Staffing levels, skill mix and caseloads were planned and reviewed so that people received safe care and treatment at all times. We found that there were sufficient registered nurses on duty, and nursing numbers were monitored daily.
- The number of staff planned and actually on duty was displayed at the ward entrances. Staff were allocated to patients for the duration of the shift.
- The wards appeared to be adequately staffed and staff numbers were within the published document by The Royal College of Nursing, July 2013: 'Guidance on Safe Staffing Levels in the UK. However, the perception of the staff generally, was that this was not the case. Some administration functions seemed to have had the most staff shortages.
- Staff reported to us that the permanent staff mostly covered vacant shifts by working extra. The ward staff reported that they had high agency usage. However, data showed that Ward 10 had relatively low levels of bank (4.8%) and agency (1.5%) staff used, although Ward 11 used 12% bank and 6% agency staff. Compared to levels nationally this is low.
- Agency staff were given an induction to the wards. Staff told us and we saw from the rota that any agency staff that were used, worked regularly at the hospital.
- The vacancy rate in June 2015 for Ward 10 was 9.8% and Ward 11 was 17.7%. This was against the vacancy rate of 10 (4%). for all registered nursing staff in the hospital.
- Sickness rates were high; 8.7% for Ward 10 and 8.6% for Ward 11, against a hospital rate of 4.3%. Most of the sickness was long term rather than short term.
- A staffing review was being carried out by the senior team at the time of our inspection.

Medical staffing

- At the time of our inspection, there were thirteen consultant oncologists who had in-patients on the wards.
- Doctors of all grades at MVCC were almost fully recruited to. None of the doctors told us they felt that the service was understaffed. Therefore, the use of locum staff was rare. Doctors on duty ranged from F1 (newly qualified doctors) to Specialist Trainees, all of whom were attached to a team.
- Junior doctors told us they felt well supported by the consultants, both whilst they were on site and if they needed to be called out of hours. They described the training they received as, "very good." There were regular consultant led ward rounds, teaching rounds, teaching meetings and MDT, which junior doctors attended.
- There was a formal hand over from the doctor on night duty, to the doctors on day duty at 8:30 am.
- The Medical rota had a weekly seven day cover for the wards which included a consultant and specialist trainee. In addition there was an anaesthetist on call for emergencies.

Major incident awareness and training

- There was a major incident plan available on the trust's intranet. However, we did not ask staff about this during the inspection.

Are medical care services effective?

Requires improvement

We rated the effectiveness of care services on the wards as requires improvement.

There was limited awareness of Mental Capacity Assessments and DoLS.

30% of patients being treated at MVCC received antibiotics within an hour if they presented with suspected neutropenic sepsis. However, not all presented at MVCC, some were treated in other trusts.

Staff had access to induction, training and appraisal systems, although there was no system of supervision for nursing staff.

There was evidence of local clinical audits and action required at ward level.

Thrombosis rates were 4.3%, whereas nationally they were 6.67%.

Intentional rounds were carried out to assess pain and symptom relief. There was a daily MDT handover and a weekly in-depth MDT patient review. The wards were covered by a consultant seven days per week and interventions were carried out at weekends.

There were effective systems in place to ensure that staff were registered to work with their professional body.

Evidence-based care and treatment

Medical care

- Patients had their needs assessed on daily clinical ward rounds. Their care goals were identified and their care planned and delivered in line with evidence-based guidance, standards and best practice.
- Clinical nurse specialists were utilised in some areas to ensure that patients with complex needs were supported. However, it was reported that clinical nurse specialists were not employed or were in short supply in some specialities, although the trust told us that recruitment was underway.
- As part of their treatment, which was often ongoing within the wards, patients were offered complementary therapies which were all evidenced based and shown to improve the patients' well-being.
- There was a sepsis improvement plan in place dated May 2015, which was a trust wide document. We saw minutes from the trust's sepsis group meeting, who met bi-monthly and who planned to recruit two nurses and to improve the current level of patients who received antibiotics within an hour..
- Staff reported that clinical policies and guidance were available on the hospital intranet and hard copies were kept on the wards.
- Both wards reported that they had undertaken audits on nursing documentation. Audits were carried out on the wards to check the environment, that staff were adhering to infection control guidance and certain aspects of care, including care of vascular devices and urinary catheter care
- The audit results were kept electronically. The results for January to June 2015 indicated that the environment was maintained well on both wards (100% overall scores). On ward 11, an area for improvement was care of vascular devices (92%).
- There was an audit of Advanced Care Planning (ACP) decision making and documentation on both Ward 10 and 11. The audit was in progress at the time of our inspection and had started in March 2015.
- Inpatient nursing documentation was audited monthly and reported to the trust. In 2013/14 the audit of documentation in patient health records, inpatient episodes, showed an overall 62% adherence with standards such as date and timing entries. This was an improvement from the previous year's results of 44%. Recommendations implemented following the audit were continuing to raise awareness of the standards.
- An action plan had been drawn up and we were told that issues had been added to the risk register. We asked to see the ward risk register; however, this was not made available. We did see the hospital's risk register, which demonstrated that the environment had been recognised as an overall risk.

Pain relief

- Pain of individual patients was assessed and managed.
- The most recent inpatient survey results, June 2015, indicated effective pain relief was experienced by patients on Ward 10 (95%) and Ward 11 (93%). In addition patients told us that they had received appropriate pain relief. Intentional rounding was carried out on the wards to ensure patients were comfortable. Whilst we saw evidence of this, some of the charts were incomplete.
- Ward 10 data showed that they administered pain relief as prescribed 100% of the time. No data was submitted for Ward 11 against this.
- Medication administration records indicated when patients could be given further as necessary (PRN) medication. This meant patients could have additional pain relief when it was required. Patients told us they were given pain relief and were comfortable.

Nutrition and hydration

- The patients told us that the food was good and the menu offered a large variety of choices covering both religious and dietary needs. A weekly menu leaflet was given to the patients to select meals.
- We observed that all the patients had drinks within their reach. In addition there were regular drinks rounds. Patients told us that staff went the "extra mile" to obtain what the patient wanted. One patient told us that they wanted cherry tomatoes, cheese and biscuits at 10.00pm and it was provided for them. Relatives were encouraged to help with their loved ones' food at meal times.
- We were told that patients were assessed by a dietician when screening demonstrated a risk of malnutrition, or if there were medical conditions that compromised a patient's nutrition, an example, nausea when having chemotherapy treatment.
- We looked at nine sets of care records and found them to be incomplete with regards to nurse assessment and actions, diet charts and fluid balance. This was evident in patients receiving Intravenous therapy, fluid irrigation and output monitoring.

- The patient-led assessment of the environment (PLACE) survey score for the hospital 95% for food in 2015. We saw a specific action plan following the PLACE audit to ensure improvements were made.

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected and monitored.
- The Mount Vernon Cancer Centre had a strong reputation nationally for contribution to national clinical trials. The centre had good recruitment to trials and contributed to improved outcomes through developing new treatment protocols.
- A key indicator of successful access to treatment is access to intravenous antibiotics within one hour for patients who were suspected of having neutropenic sepsis. An audit of 47 patients had been carried out in April 2015 and showed that across the east of England network, 30% of patients who were suspected of having neutropenic sepsis received antibiotics within two hours of admission. 4% of patients waited four or more hours. This was an improvement on 2014, when less than 20% of patients received their treatment within an hour. However, the audit showed that in 25% of admissions, it was unclear when the first dose was given. Although these patients were having their cancer treatment at MVCC, they may have been admitted to their local trust rather than directly to MVCC. For those admitted directly to MVCC the results were better and showed that 82% of patients received antibiotics in one hour and 91% of patients received antibiotics in two hours. Education was ongoing with regards to the role of the acute oncology service within MVCC and neighbouring trusts in order to highlight patients who required antibiotics rapidly.
- Trust wide septicaemia mortality data from Dr Foster for the rolling year ending June 2015 was 82 (HSMR) and 88 (SHMI). However, these patents had not all been treated at MVCC.
- There was a sepsis improvement plan in place dated May 2015. We saw minutes from the trust's sepsis group meeting, who met bi-monthly and planned to recruit two nurses and to improve antibiotics received within an hour to 95%.
- Thrombosis rates were 4.3%, whereas nationally they were 6.67%.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment and took on new responsibilities.
- There were systems in place, managed by the HR department with regards to revalidation and registration with the relevant professional bodies.
- All the staff we spoke with confirmed they had undergone both a trust wide and local induction, most reported to us it was useful and relevant.
- All agency staff underwent an induction. We saw evidence of this. An agency nurse we spoke with confirmed that they had received an induction to the ward.
- The doctors we spoke with felt they had good access to training and could get advice from the consultants as required.
- 88% of staff on Ward 10 and 84% on Ward 11 had undergone an appraisal within the last year, against a trust target of 90%.
- There was no formal clinical supervision for nursing staff.
- A nurse told us that there were opportunities for learning and development particularly around enhanced clinical skills to support cancer patients; for example administration of chemotherapy. Records provided showed that nursing staff had undertaken training including:
  - All the senior nursing staff (band 6 and up) were up to date with their immediate life support (ILS) course that was attended annually.
  - Five of the senior nurses had completed or were in the process of completing a postgraduate critical care course.
  - Five out of the eighteen senior nurses had completed critical care transfer training at Northwick Park or the Marsden.
  - Five senior and 10 Band 5 nurses had completed the ALERT (a multi-professional course in care of the acutely ill patient) course in 2015.
- During our visit to the wards we observed that staff were professional and competent in their interactions with colleagues, patients and relatives. We observed an allied health professional working with the patients, relatives and nursing staff on the wards.

Multidisciplinary working

Medical care

- Staff we spoke with reported that they worked well with all the multidisciplinary team, including doctors, therapists and social workers. We observed daily multidisciplinary patient handovers.
- There was a daily full team handover from the medical staff on night duty and multidisciplinary ward rounds were carried out daily.
- When patients were required to attend other hospitals for treatments and investigations we saw that staff had good working relationships with their teams. Staff we spoke with found the input of other clinical teams and nurses to be very good. The daily staff handover meeting helped with communication.

Seven-day services

- There were lead consultants on the duty rota who were in attendance seven days per week with a specialist trainee.
- There was seven day availability, on call out of normal working hours, of diagnostic services including imaging, emergency radiotherapy and laboratory facilities. Some services had to be accessed off site, for example procedures to insert drains or carry out biopsies under radiological or ultrasound control.
- A pharmacist was based on the wards to review all medications and attend the daily MDT meeting. In addition there was an on call service for emergencies.

Access to information

- Information was available to deliver effective care and treatment to relevant staff in a timely and accessible way. Chemotherapy prescriptions and treatments were in an electronic format, all other documentation was paper. However, as the patients records were in a paper format, staff reported there was often a challenge to find them, particularly if the patient had interacted with several different departments.
- We saw some nursing assessments that were poorly photocopied and unclear.
- There was easy access to diagnostic results such as blood results and imaging to support the staff to care safely for patients.
- When people moved between teams and services, including referral, discharge and transfer, all relevant information was sent to ensure their ongoing care was shared appropriately, in a timely way.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had an up to date consent policy that staff were familiar with. The hospital consent forms complied with Department of Health guidance.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people.
- Patients told us that staff obtained verbal consent before giving care or treatment, this was also observed.
- We looked at nine sets of notes and saw consent forms were fully completed, signed and dated by the consultant, or specialist nurse and patient. If the patient was to undergo chemotherapy, the forms identified the planned treatment, the associated risks and benefits and intent of treatment. In addition, there was an associated toxicity profile. We saw two separate consents for when the patient was taking part in a clinical trial in conjunction with the hospital's research centre. These were signed by the consultant and patient.
- We saw from the trust's training records that one of the senior nurse's had undergone 'Train the trainer' teaching. However, the staff that we spoke with had not had any training and generally there was limited understanding by staff of Mental Capacity Act and Deprivation of Liberty Safeguarding (DOLS).
- Staff we talked with knew that there were contact phone numbers on boards in the wards areas for the safeguarding leads in the hospital.
- We saw no care notes containing Mental Capacity assessments or DOLs.

Are medical care services caring?

Good

We rated the caring on the wards as good.

Patients received compassionate care and were treated with dignity and respect. Patients and their relatives were positive about their experiences of care and kindness offered to them. Patients told us that they were involved in decisions about their care and treatments and were given appropriate information.

Medical care

Staff understood the patients' emotional needs and spent time talking with them. Emotional support was provided by staff in their interactions with patients. Most patients were positive about their experience.

Compassionate care

- Staff took the time to interact with people and those close to them on both wards. This was done in a respectful and considerate manner.
- Data from the latest trust wide cancer inpatient survey results showed that there were six negative comments, which is within the bottom 20% of trusts for those 6 questions. There was one positive comment and the rest were neutral.
- We observed that interactions between nursing staff and patients were professional, kind and friendly. Several patients told us that they thought the nursing was good. Patients felt that staff really cared. One told us that their consultant had come into the hospital on a Saturday to explain their prognosis to their children.
- Some of the positive comments we received from patients were; "It has been a privilege to be cared for and treated by this team. "They give me time to cry and hold hands." "It's idyllic, one could stay forever." "They tried everything to relieve my nausea." "I don't have to worry about being in pain. They're on it."
- Patients told us that nursing staff were respectful to them and every effort was taken to ensure their privacy was protected when personal care was given. However, we observed that there was difficulty in closing curtains due to the limited bed space between beds.
- We observed patients receiving complementary therapies on the wards; for example massages.
- The Friends and Family Test (FFT) for August 2015, where the response rate for Ward 10 was 78% and showed that for seven months, the score was that 100% of patients would recommend the ward to friends and family. The remaining five months scores were between 96% and 98%. Ward 11 overall response rate was 63% and for four out of 10 months the score was 100% of patients would recommend the ward to friends and family. The remaining six months scores were between 94% and 95%.
- A spot-check of FFT for August 2015 showed that the wards had maintained their positive results, (94% for Ward 10 and 95% for Ward 11). However, whilst Ward 10's response rate was 79%, Ward 11's was only 37%.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they were involved in their care planning and understood their treatments and choices. Some patients reported that they had to ask the nurse to interpret what the doctor had said as they did not understand some of the words used. Patients and relatives felt they could ask questions of the staff.
- We observed nurse, doctors and therapists introducing themselves to patients and relatives and involving patients in decisions about their care.
- Welcome information was available on the wards for patients and their relatives, which informed them about visiting times, meal times and access to the hospital.
- There was a translation service available which staff knew how to access.
- Patients and relatives reported that they received good communication on the ward with regards ongoing treatments.
- Patients told us that there was good communication between the hospital and their GPs. Most, although not all patients, were copied into the letters regarding their treatment to their GPs.

Emotional support

- Patients and relatives told us that the clinical staff were approachable and that they could talk to staff about their fears and anxieties. There were quiet rooms on the ward for patients and relatives to use.
- Patients had access to complementary therapies while on the ward and other specialist services based in the hospital could be accessed, for example, social care and palliative care
- The hospital had chaplaincy services which offered multi-faith support on request. Staff were aware of how to contact spiritual advisors to meet the needs of patients and relatives.

Are medical care services responsive?

Inadequate

We rated the responsive aspects of the wards as inadequate.

Medical care

The buildings were old, there was a lack of space and some services were away from the wards. This meant patients had to be transported outside. Their needs, when it was cold or raining, were not always met. The hospital told us that bed covers had been ordered. This did not address patients in wheelchairs.

Due to limited space at the bedside, personal care and treatment discussions with patients could be clearly overheard by other patients and their relatives.

There had been no specific training to care for patients with dementia.

Patients often had to wait several hours for their take home medicines to be dispensed.

Numbers of complaints were low, however, most, especially verbal complaints, were not recorded on the trust's system.

Patients had timely access to initial assessment, diagnosis or urgent treatment. Where it was found a patient may breach a waiting initiative, they were prioritised for urgent treatment.

Discharge plans tended to be planned a day ahead.

Nursing staff had been nominated for an excellence award by the radiotherapy team for the care of a patient with a learning disability.

Service planning and delivery to meet the needs of local people

- An electronic referral and booking system was in place which linked local hospitals directly to MVCC. Although this was a recent improvement, it was introduced in an effort to reduce booking delays. Treatment for people with the most urgent needs was prioritised.
- Most of the patients were on wards 10 and 11 following urgent referral, to treat symptoms caused by their treatment, for example, difficulty in swallowing and nausea.
- As the hospital's catchment area was so large, many of the patients did not live locally. Therefore some had been admitted because they were undergoing daily radiotherapy or chemotherapy and travelling would have been too arduous for them and they were not well enough to reside in the on-site hostel.
- There was a café where both patients and relatives could get refreshments.
- There were dedicated administrative staff for scheduling and booking beds. This ensured focus on getting patients to treatment quickly. They booked all parts of the pathway (including patients having radiotherapy and chemotherapy at the same time). Staff were based with the MDT coordinators and the secretaries so there was a good exchange of information.

Access and flow

- Patients had timely access to the wards should they need admission. Ward 10 bed occupancy rate was 63% and Ward 11's was 97%. Beds were always available if required.
- The wards had access to specialist teams, and a full range of allied health professionals written entries from the MDT were seen in patients' records.
- There were allocated social workers for the wards, who supported discharges. Discharges were managed by the ward and were mostly planned one day ahead. Discharge arrangements were discussed at the daily staff handover.
- There were often delays for patients waiting to be repatriated to acute hospitals nearer their homes, due to the acute trust's bed pressures. However, MVCC had no influence over this.
- We observed one patient being told they would have to wait between two and three hours for their take home medications on day of discharge, this was because of the volume of work in the pharmacy.

Meeting people's individual needs

- The hospital was housed in an old building. Several of the departments were in separate buildings, which meant that if patients were attending other departments, they had to go outside to access them. We saw patients on trolleys and in wheelchairs being wheeled outside, in the rain. One patient, who was on a trolley, had an umbrella held over their head; however, the rest of the trolley was getting wet. Another, in a wheelchair had their dressing gown and pyjamas on and were covered with a blanket. However the person pushing them was wearing a thick waterproof coat. Senior staff told us that trolley covers had been ordered. However, it seemed accepted that patients needed to go outside and our observations showed that their individual needs were not always met.

- Side rooms were available on both wards and where necessary patients of either sex could be admitted to the side rooms on the wards, in order to manage demand. However, there was no documented contingency plan if one ward had to close.
- A patient was allocated the same side ward throughout a four-week stay even though they had short stays at other hospitals for treatment so that they felt that their needs were responded to.
- The hospital had links with the specialist Learning Disability (LD) team at The Lister Hospital, who provided support when needed. There were LD link staff in each department. However, the LD link team was a recent initiative and two link staff told us that they had not had the opportunity to attend learning sessions or meetings about their role. The staff told us that they made adjustments and provided extra support for patients with a learning disability, for example, the same nurse cared for the person, in order that a relationship could be built up. This extended to nursing staff working outside their own department in an effort to provide support and continuity. However, staff we spoke with were unsure about any other provision or the availability of easy read advice leaflets.
- We were told that the nursing staff had been nominated for an “excellence award" by the radiology team for the care of a patient with a learning disability who had found their treatment very distressing.
- None of the staff we spoke with had received training to support people with dementia. However, they said they would ensure any patient who had particular needs would be given extra assistance.
- There was an Access to Interpretation services flowchart. This was used to ascertain the assistance a patient may need if they had a communication difficulty. This included both language and sensory difficulties. The flow chart gave the contacts so that staff could access the correct assistance. Telephone translation services were available.
- Staff reported that they were able to access translation services for patients whose first language was not English. Staff could book interpreters services to attend the ward or use telephone access. However, we found that often the services of staff were used to provide translation.
- Patients told us that staff went the “extra mile” to obtain what the patient wanted. One patient told us that they wanted cherry tomatoes, cheese and biscuits at 10.00pm and it was provided for them.
- Free Wi-Fi was available for patients.
- The hospital provided educational podcasts for patients.
- There was a multi faith chapel and a separate prayer room, both used for religious services, or quiet prayer and contemplation.
- Information both verbally and in writing was available for a range of conditions, their treatments and associated needs, for example with regards to hair loss.
- Although both wards had a number of side rooms, the environment layout of the beds on the wards did not enable patients to have personal space or to have confidential conversations without being overheard. We observed on both wards curtains drawn between patients’ beds so they could have some privacy. There were quiet rooms in which difficult or confidential conversations could happen away from the ward area.
- We observed the Phlebotomist taking bloods without closing the curtains.
- The patient-led assessment of the environment (PLACE) survey score for the hospital was 98% for privacy and dignity in 2015. We saw a specific action plan following the PLACE audit to ensure improvements were made.

Learning from complaints and concerns

- Ward staff told us they received very few complaints. They used local resolution in the first instance, and formal complaints were processed via Patient Advice and Liaison Service (PALS) who gave formal feedback on actions taken.
- There were notice boards in the staff room that displayed information regarding compliments and complaints.
- The medical staff told us that learning from complaints and incidents took place at handover. The medical staff we talked with knew how to record a complaint on the trust’s electronic system, but those we spoke with had never done this.
- There were a low number of complaints. Data provided by the trust showed there were 17 complaints for the two wards, for the year ending March 2015. However, we found that not all complaints, and particularly verbal complaints, were logged on the trust’s system and were

instead stored locally. Most staff we spoke with thought that if a complaint was verbal, it was not formal and therefore was not logged. This meant the trust may not have had an overview of all complaints.

Are medical care services well-led?

Requires improvement

We rated the well-led aspects of the ward as requiring improvement.

Staff had limited awareness of the Trust's vision and values. The leadership team could articulate their plans for the future, but did not have this as a recognisable written strategy agreed by the trust. Staff we spoke with, both clinical and managerial, during the inspection were not aware that there was a defined cancer strategy in place that detailed the actions to be taken in developing the service, or the part they and their team played in the development and improvement of the service.

Urgent transfers out of the hospital were not recorded formally. This meant that MVCC management team had not fully recognised the risks surrounding the deteriorating patient and had no plans to address them. In addition, there was no oversight of why and where patients were being transferred to in order that their treatment could continue. The trust had no plans to address this longstanding risk. However, since the inspection took place the trust told us that in response to the concerns raised during the inspection, oversight had been improved through the introduction of a transfer follow up book which allowed updates to be recorded and monitored.

We observed a culture where some nursing staff were resistant to change and where some staff felt that not all team members worked to a sufficient level of seniority reflective of their grade.

Individually the leadership team at Mount Vernon Cancer Centre were strong and capable. The Cancer Management team were recognised by everyone we spoke to as being highly effective and were valued by members of the clinical team. The trust executive team were less visible in non-clinical areas. There was a positive culture; staff felt engaged in (and part of) the Mount Vernon Cancer Centre.

There was new nurse leadership in place, and action plans for staff skill reviews and development had been commenced.

Vision and strategy for this service

- The leadership team could articulate their plans for the future. However, the service's leaders could see where shortfalls were and how they could be improved. This mostly surrounded the building infrastructure and providing a modern service within an ageing building, much of which was not fit for purpose.
- A brief outline of the cancer centre's objectives was provided for us to see after the inspection, dated June 2014, was not referred to during the inspection and did not contain what would be expected in a strategy document. For example, it outlined objectives, which were incomplete, there was no team or person referred to who had responsibility for achieving individual objectives and there were no measures in place to ascertain how and whether the objective had been achieved.
- Staff we spoke with, both clinical and managerial, during the inspection were not aware that there was a defined cancer strategy in place that detailed the actions to be taken in developing the service, or the part they and their team played in the development and improvement of the service.
- Staff had limited awareness of the trust's vision and values. There was a culture within some of the nursing staff that were resistant to change. Some staff were reported not to be working to a sufficient level that denoted the seniority of their grade.
- There was new nurse leadership in place, action plans action plans for staff skill reviews and development had been commenced.

Governance, risk management and quality measurement

- Patients who developed complications during their treatment and who required medical or surgical treatment were transferred to one of the neighbouring trusts by emergency ambulance. This happened up to twice per week. The wards had a summary of all transfers; however, a trust incident report was not completed. This meant the hospital did not have an oversight or did not monitor the number and reasons

for transfer. For example, there were five transfers following one type of cancer treatment, due to bleeding. The consultant was not aware of this recurring complication until the fifth patient had been transferred.

- The senior managers told us that patients were transferred back to their referring trust; however ward staff, who were managing this on a daily basis, told us patients were taken to wherever the ambulance took them. For example the ambulance, depending on where they were based, would often decline to transfer a patient to The Lister as it was too far out of their area. We spoke with one junior doctor, who was not aware of this transfer process, but was due to undertake their first on call shift during the week of our inspection.
- The leaders had not recognised the risks of transferring acutely unwell patients out of the hospital via an ambulance. Urgent transfers out of the hospital were not recorded formally.
- Therefore, the trust was unsighted on this risk and no actions had been taken to address this concern.
- Although negotiations were ongoing with Hillingdon NHS Trust with regards to transferring the building to East and North Herts control and there were verbal plans for improvement. However, there was no firm plan in place to improve the building and environmental issues.
- There was a lack of oversight about the negative results of the cancer experience survey.
- Nurse leaders reported that they had staff meetings; however the attendance could be low. For example, only two staff attended the last ward meeting on ward 10.
- We saw that ward managers were providing regular reports on incidents and that the reports were displayed in the respective staff rooms.
- We spoke with the ward managers and there was a good awareness of governance arrangements. This included incident reporting and undertaking audits in order to improve care. However, whilst we told that there was a ward based risk register, we were not supplied with this document.
- All the staff we spoke with felt it was easy and open to raise concerns.

Leadership of service

- There was a strong leadership team in the Mount Vernon Cancer Centre. However, some longstanding risks had not been recognised. The Cancer Management team were familiar to everyone we spoke to as being effective and were valued by members of the clinical team. The trust executive team were less visible in non-clinical areas.
- There was a positive culture; staff felt engaged in (and part of) the Mount Vernon Cancer Centre. We observed ward managers and consultants on the wards and it was clear that they knew the staff. Ward managers and sisters reported they had a lot of support for their senior manager.
- The service had strong individual leaders in place following some recent changes and roles were being reviewed to ensure appropriate nurse banding levels and skill mix.

Culture within the service

- Staff described the wards as good places to work and some had been on the wards for many years. They told us: “It’s like its own little community.” “I get up in the morning and I’m keen to get to work.”
- Staff reported that they were comfortable reporting incidents; however nurse leaders felt there was an under-reporting culture at some levels.
- On the wards we observed that staff worked as a multi-disciplinary team which included patients and relatives, therapists, nursing staff and doctors.
- Patients we spoke to acknowledged a positive and caring ethos and were happy with their experiences of care. Where there were concerns patients felt able to raise them with staff.
- Some staff reported to us that they felt like the poor relations compared to the main trust site.

Public engagement

- Thank you cards were displayed on the wards; comment cards were available for patients and any visitors to make comments on. We saw the comment cards displayed for all to see.
- There was a patient experience committee that was held regularly. This was chaired by a non-executive director. It included six patient representatives and considered comments and complaints received by the services.

Staff engagement

- Communication to staff was through regular trust newsletters, but these were not specific to Mount Vernon Cancer Centre.

- Specific meetings were set up by team leaders to engage staff on specific issues.
- Staff were encouraged to populate the staff meeting agenda to ensure that it covered topics that were meaningful to them. However, we saw that staff meetings on both wards were held infrequently and attendances were poor.

Innovation, improvement and sustainability

- Staff were proud of the developments in the service, and told us there was an effective process for introducing new ways of working.
- The process for recognising and responding to patients who had deteriorated and required extra care had improved over the months prior to our inspection.

End of life care

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

Information about the service

Mount Vernon Cancer Centre (MVCC) is based in Northwood, Middlesex. There were over 500 members of staff treating a catchment population of almost two million. Their facilities included Michael Sobell House palliative care unit (MSH)

MSH provided both inpatient and day care services. MSH was opened in February 1977 and had16 palliative care beds. MSH aimed to improve the quality of life for patients by providing symptom management, rehabilitation, carer support or for care in the last days of life. The term palliative care describes care given to relieve symptoms rather than treat the cause of an illness, the aim of which is to improve the quality of patient's life who has a life-limiting illness. Palliative care can help at all stages of such an illness, from its diagnosis, during on-going treatment and at the end of someone's life.

In the inpatient unit the staff comprised of a multidisciplinary team including nurses, care assistants, consultants in palliative medicine, medical team, rehabilitation team including Occupational Therapist and Physiotherapist, Social Work practitioner and patient and family support team, complimentary therapists and large volunteer workforce.

There was also a consultant led outpatient service and a hospital support service providing advice and support to all clinical areas in MVCC..

The day care service opened in 1982. Some services were funded by a charitable trust, staffing was managed by East and North Herts Trust. The service aimed to support patients with palliative care needs and enabled them to maintain their independence in a safe and supported environment.

The service provided help for patients' carers. The day centre team provided advice on symptom control, as well as counselling, complementary therapies, creative arts as therapy, crafts and outdoor activities. There were 12 places, four days per week. On Mondays, places were reserved for carers to attend. Staff offered carers counselling and provided them with advice and information. Carers could meet and spend time with other carers and in addition could have complementary therapies. On Tuesdays, staff administered a number of clinical procedures such as infusions. Wednesday was specifically for women to attend and Thursday was a day specifically for men. Places on Friday were for both men and women but tended to be for the older adults. The day centre team worked collaboratively with community services (GPs, Macmillan nurses and district nurses) to enhance the advice and support each patient received from their community team.

The MSH teams were line managed by the head of palliative care, which is based at MSH 0.5 whole time equivalent (WTE) 2.5 days per week.

Most patients using MSH were from the boroughs of Hillingdon, Harrow, or from Hertfordshire or Buckinghamshire. However, because of their links with the Cancer Centre, which had a wide catchment area, sometimes MSH accepted patients from further afield.

Nearly 1800 people died in the trust's hospitals every year, representing over 50% of the deaths that occur in their

End of life care

catchment population. In addition, significant numbers of people are cared for in the trust at some time during the last year of their life. The trust told us the Specialist Palliative Care Team (SPCT) that covered Lister Hospital and Mount Vernon Cancer Centre had received 1879 referrals between April 2014 and March 2015. 949 were people with cancer and 413 were people without cancer.

End of life care, 'helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both the patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms, psychological, social, spiritual and practical support.' (National Council for Palliative Care 2006) End of life care is for those 'likely to die within the next 12 months'. (General Medical Council 2010).

During our inspection, we spoke with two patients and two relatives. We also spoke with 12 members of staff which included; the palliative care team, nursing, medical staff and day services manager. We observed care and treatment and looked at care records and five Do Not Attempt Cardio-Pulmonary Resuscitation forms (DNA CPR) within MSH. We received comments from our listening event and we reviewed the trust's performance data.

Summary of findings

We found the service to be caring and responsive but it was rated as inadequate for safety and required improvement in effectiveness and to be judged well led.

The fabric of the building was old, tired and dirty. We saw a number of maintenance issues of concern that had not been identified or addressed and were not on the service risk register. We saw that cleaning standards were poor.

When things went wrong, reviews and investigations were not always thorough. The managers did not always identify or make the necessary improvements. Relevant managers had reviewed incidents, but there was limited evidence that any action had been taken to reduce the risks. It was clear that no manager's action or comments were documented with regards to some incidents. However, incidences were discussed at the bi monthly departmental clinical governance sessions.

We saw that staff had overlooked patients' capacity to make a decision on occasions. Staff had used pressure sensor equipment to reduce the risk of a patients falling. We did not see any assessment of a patient's capacity about the use of the equipment with the patients, or those close to them documented in the patients' notes. The trust told us staff used the least restrictive method of ensuring safety. The pressure sensor did not restrict movement and patients were able to get out of bed/ chair. The sensor alerted staff to the fact that the patient had got up and at risk of falling. This enabled the staff to be able to go and support the patient

The trust had a replacement for the Liverpool Care Pathway (LCP) called the Individual Care Plan for the dying person (ICP). (The LCP was a UK care pathway covering palliative care options for patients in the final days or hours of life. It provided guidance to help doctors and nurses provide quality end-of-life care. The Department of Health phased it out in 2013 after an independent review). The ICP provide guidance for staff to ensure that people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. The SPCT monitored the implementation of the IPC.

End of life care

The service did not have the all the processes and information to manage current and future performance and did not collect information of the percentage of people who died in their preferred location. The service did not collect information of the percentage of people discharged to their preferred place within 24 hours. Without this information, they were unable to monitor if the service was honouring peoples' wishes and if the trust needed to make any improvement on this.

Are end of life care services safe?

Inadequate

We found that end of life care at Michael Sobell House (MSH) with regards to safe care, was inadequate.

The hospital told us there were currently no risks associated with end of life care and were unable to give us any further detail. However, some of the risks that we saw associated with medicine or cancer may have been partly relevant to end of life care.

Information about safety was not always comprehensive or timely. Safety concerns were not always identified or addressed quickly enough. This meant there was a risk that the MSH team may not always be aware of incidents relevant to them. When incidents occurred, reviews and investigations were not always adequate. Improvements were not always made when things went wrong. There was evidence of incidents being reviewed by the relevant manager, but where an action to mitigate against future risk was required there was limited evidence that this had been addressed. On some incident reviews there were no managers action/comments documented.

The environment had not been well maintained and there were areas of risks that had not been addressed by the service. These concerns were brought to the attention of senior staff during the inspection.

Systems, processes and standard operating procedures were not always consistent to keep people safe. We had concerns about some of the arrangements for the management of medication; in the clinic room we saw a number of expired enteral feeds, and expired dressing packs on the shelves.

We saw evidence that people received a timely apology when something went wrong and were told about any actions taken to improve processes to prevent the same happening again.

Safeguarding was given sufficient priority and staff took a proactive approach to safeguarding. There was a focus on early identification and steps to prevent abuse from occurring were taken.

Incidents

End of life care

- MSH used the trust's incident reporting policy. We were confident that staff we spoke with at MSH understood their responsibilities to record safety incidents, concerns and near misses and to report them using the electronic reporting system.
- There had been no never events or serious incidents reported between May 2014 and April 2015 for end of life care services. A never event is a serious incident that is 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 104 incidents reported between 1 August 2014 and 31 July 2015 from MSH. There was evidence that the relevant manager had reviewed all incidents but where an action to mitigate against future risk was required, there was limited evidence that the manager had addressed the issues. For example, 31 incidents reported were due to patients noted as having pressure ulcers on admission to MSH. There was evidence that staff had assessed and provided pressure care once the patient had arrived at MSH. However, there was no evidence that feedback had been given to the service from where the patient had been admitted. We could not be confident that the services these patients had been admitted from were aware of the issue. Without this information, they were unable to monitor whether or not liaison work was needed to make improvements.
- Ten incidents were due to medication errors. For example; in June 2015 a patient was administered 5 milligrams (mgs) of Oramorph instead of the prescribed 2.5 mg. Immediate action was documented, doctor, patient and family were informed, recording of the patient's blood pressure, pulse and respirations were carried out and staff observed for any signs of toxicity. (Oramorph is a liquid form of morphine, which is used as a painkiller, in small doses Oramorph is used for the relief of long term or chronic breathlessness.) The trust had scored this incident as a very low risk as no harm had occurred to the patient. There were no documented manager's action/comments. A medication error of this type does have an effect on the patient which could have caused harm. We did not see evidence that the relevant manager had completed a documented investigation of why this had occurred or a plan in place to reduce the risk of an incident such as this re-occurring.
- 37 incidents were the result of patients falling. There was evidence that staff had implemented and followed fall prevention care plans.
- The trust told us that there were currently no risks associated with end of life care on the trusts electronic incident reporting system. However, some of the risks associated with medicine or cancer may have been partly relevant to end of life care. At the time of inspection the trust was not able to give us any further detail. There was a risk that the MSH team may not always have been aware of incidents relevant to them. Since inspection the trust told us MSH were fully aware of End of Life incidents that were relevant to the service and these were discussed in clinical governance meetings. They told us both the head of palliative care and clinical care were notified of MVCC incidents regarding End of Life care, or palliative care issues via the electronic reporting system.
- Staff told us that managers told them about lessons learned from investigations of trust wide incidents at the clinical governance meeting. The trust told us that the ward sister presented incidents at the bi weekly sisters team meeting. This made sure staff were aware of and took action if necessary to improve safety beyond the affected team or service.
- Staff we spoke with were aware of their responsibilities with regard to duty of candour. (Duty of Candour regulation was introduced for all NHS bodies in November 2014. This meant that organisations should act in an open and transparent way in relation to care and treatment provided to patients). The staff we spoke with were able to provide examples of situations when an incident had occurred, how they had informed the patient and their relatives of the incident, made an apology and explained how the hospice had responded to the incident.

Safety thermometer

- The service used the NHS patient safety thermometer. The hospice team displayed the October audit results on a white board on the ward. In October, no falls and no new pressure ulcers were reported. We saw evidence that staff had undertaken risk assessments for patients. We saw falls prevention assessments, and assessments of risk for patients developing pressure ulcers. Staff had put care plans in place to address the risks highlighted.

Cleanliness, infection control and hygiene

- We saw that there were areas for improvement with regards to cleanliness. For example in bay one we saw insects and cobwebs in the corner of a window. Staff told us that they had very little cleaning time. A cleaner worked 7.30am until 1.30pm daily to clean both the inpatient and day care areas. Staff felt that more time was required and told us that they had fed this back at the facilities management meeting. At the time of inspection, the trust had not addressed this issue.
- We found that the cleaning schedule for equipment worked well. We saw equipment such as commodes, were clean and had: 'I'm clean' stickers on. This ensured that staff used clean equipment.
- Staff wore clean uniforms with arms bare below the elbow, in line with the trust's policy. We saw staff wearing the correct personal protection equipment (PPE) such as gloves and aprons according to trust protocol and we observed PPE to be accessible throughout the hospice.
- Hand gel was available at the hospice entrances and throughout for visitors and staff to use. We observed staff and visitors using gel appropriately.
- We saw that the last hand hygiene audit had been 100% compliant.
- Dirty linen bags were on the floor and were not stored in the linen cupboard, in line with the trust's infection control protocol.

Environment and equipment

- There are four, four bedded bays and four rooms. The fabric of the building was old, tired and dirty; wall coverings were peeling and dented. We saw a number of maintenance issues of concern. Staff had not identified or addressed these issues. For example, in bay three, the fire exit sign was loose and the radiator was too hot to touch. We saw brown stained fluid on the floor, in one of the bathrooms. The radiator in this room was also too hot to touch.
- In bay four, there were two soiled electronic mattresses and their motors in stained equipment bags on the floor. In patient areas, equipment cluttered the environment. In the clinic room, we saw missing ceiling tiles which meant that there was a risk of falling debris from the loft area. We saw that on occasions, when something had broken, staff had made a temporary repair. We saw in one en-suite bathroom a piece of string had replaced the broken light pull cord and a screw had replaced a handle on a broken bedside cabinet drawer.
- In the day centre, we saw loose tiles in the art room by the sliding door. This would have been a trip hazard for anyone using these doors. However, staff told us patients did not use these doors. The floor between the art room and the day room was also damaged and was a trip hazard.
- In the inpatient area, there were many hazards for people who were frail, had mobility issues and were confused. For example, in one of the toilets the fixed toilet rail was old, not secure and had sharp edges due to wear and tear, which could have caused an injury.
- The side room door lock system meant that there were metal parts that stuck out at eye level and posed a risk to those walking along the corridor. We saw an electricity box with wires exposed. We raised these issues with staff during our inspection; they did not appear to be aware of the potential risks these issues could pose.
- Staff told us work to improve the environment had been delayed due to finding asbestos in the building. We saw red stickers in various places in the inpatient area warning of asbestos.
- MSH did not have a mortuary. It had a cooling room, which allowed the deceased patient to remain at the hospice so that relatives were able to spend time with their loved one before going to the mortuary at MVCC or a local funeral director. The cooling room was in a poor state of repair. The air conditioning system which kept the room at the required temperature was mouldy, rusty and had leaked fluid on to the bed below.
- These issues were not on the risk register for the service and there was no evidence that staff had identified and raised for them for repair.
- We raised these issues with the staff and ward manager during the tour around the unit. The ward manager reported that they would raise these issues for repair.
- We found the maintenance schedule for equipment worked well in some areas but not in all cases. For example, the resuscitation trolley, vital signs machine, suction machine and bladder scanner had test stickers in place identifying that they had been tested in a timely manner. The blood fridge in the clinic room was due for annual testing. It had a sticker on it stating the last date

it was tested was July 2014. Staff were unable to confirm whether the fridge had been tested since this date. We saw a fire extinguisher on the floor with no date test sticker.

- Syringe pumps used to give a continuous dose of painkiller and other medicines were available to help with symptom control. The syringe pumps were maintained and used in accordance with professional recommendations. The service provided evidence of a maintenance schedule and asset list of T34 Syringe drivers (Ambulatory Syringe Pump) including next service dates.

Medicines

- There was guidance for prescribing palliative medication and guidance for use of anticipatory medication at end of life. MSH provided us with a document produced by the SPCT Hertfordshire palliative care 'Just In Case' guidelines. This was a guide to prompt the prescription of "just in case" medications to have available in the home to support best practice in palliative care. This list of drugs was to support urgent symptom control for 24-48 hours if the patient was no longer able to take oral medication. Bedfordshire and Hertfordshire Specialist Palliative Care Group ratified the document in July 2014. We saw, in patient's notes, evidence of this document being used and it was available on the internal intranet in the trust's knowledge centre.
- Following a recommendation by the National Patient Safety Agency (NPSA) the trust had replaced the syringe drivers across the whole trust. The implementation was supported by a comprehensive education programme which took place in September 2013. All newly qualified nursing staff received training on this equipment as part of their induction. Staff attended on-going training to maintain competence and confidence in using the equipment. We observed nursing staff setting up a syringe driver safely according to trust protocol. Both staff members had a high level of knowledge about the medication in the syringe driver and the rationale for its use.
- A pharmacist attended the ward rounds on MSH. This provided them the opportunity to support medical staff, influence medicines management proactively at the point of prescribing and to support patients, as it increased their knowledge of patients' needs on the ward.
- Staff were completing medication/drug charts correctly. Staff had signed and dated them.
- We had concerns about some of the arrangements for the management of medication in the clinic room. We saw a number of enteral feeds on the shelves which had passed their expiry date. This meant there was a risk that staff may use a product which was no longer within an acceptable condition to be considered effective.
- We saw a bottle of Oramorph without a date indicating when staff had opened it. Without this date, staff were unable to check if the medication had passed its after opening expiry date. We also saw out of date sterile dressing packs. This meant there was a risk that staff may use products that were no longer within an acceptable date range.

Records

- We looked at seven sets of patients' records. All were dated, signed and followed the trust's note writing protocol.
- Registered nurses signed accountability forms for each shift in the patients' notes. The intention was to promote individual accountability for the care of patients. (Accountability offers the opportunity for two trained nurses to discuss and evaluate a patient's condition whilst the patient is clearly visible to both).
- We saw staff had completed skin integrity assessments to evaluate the patient's likelihood of developing pressure ulcers. There was a repositioning chart and skin inspection chart in the notes, which were completed during each shift.
- Falls risk assessments were also undertaken.

Safeguarding

- Staff that we spoke with were aware of their responsibilities for reporting safeguarding concerns and were aware how to report them.
- The majority of staff (92%) had completed safeguarding adults training. 92% of all staff had completed mandatory safeguarding children (Level 1), 91% of relevant staff had completed safeguarding children Level 2 training. All of which met the trust's target.
- There had been no reported safeguarding concerns relating to end of life care.

Mandatory training

End of life care

- All staff in the trust were expected to attend mandatory training which covered safeguarding adults, safeguarding children, moving and handling, infection prevention, equality and diversity, information governance, health and safety and fire.
- Overall compliance with mandatory training at July 2015 was 87.7%. Compliance with the training was mixed, for example 57% of staff were 100% compliant and had completed all their training, and 3% had completed none of their training.
- End of life care training was included in the trust's mandatory training.

Assessing and responding to patient risk

- The team discussed the referrals at a weekly multidisciplinary meeting. Urgent referrals were discussed on an individual basis.
- Staff we spoke with at told us that they did not use a formal triage system for their referrals. However the trusts told us that all patients were triaged at the weekly bed meeting or on a daily basis with the referrals coordinator, nurse & consultant. The trust told us there were set criteria for referrals based on clinical and social needs, decision were based on clinical judgements. All referrals and their outcomes were recorded on the 'Referral Sheet'. Staff told us that referral information had been collected for several years but nothing formally had been done with the information by the hospice or the trust. The trust told us referral outcomes information was discussed on a weekly basis by the MDT at bed meetings and an audit of outcomes was presented to the MSH clinical governance meeting
- We saw that Do Not Attempt Resuscitation (DNACPR) forms were placed on the front of the patient's notes. All had been completed and signed.

Nursing staffing

- The inpatient unit staffing team comprised 1.0 whole time equivalent (WTE) sister, 2.0 WTE team leaders (senior staff nurse), 13.26 WTE nurses and 8.21 WTE clinical support workers (CSWs).
- We looked at the staffing rota for the unit and saw that the planned staffing was four trained nurses and two CSWs on an early shift. The late shift comprised two trained staff and two CSWs. Night staffing was two trained staff and one CSW. There were no concerns raised about achieving planned staffing numbers. Staff told us they had concerns about the planned lower staffing numbers on the late shift and at night as they felt they were not able to always provide the care that people needed. The team had completed a business case and presented this to the trust to request an additional CSW for the late and night shift.
- The lead nurse used the Shelford safer nursing care tool (SNCT) every six months to monitor staffing needs. The SNCT is an evidence-based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/dependency terms. This demonstrated that the staffing levels were adequate.
- The staffing team for the day care unit comprised 1.0 WTE sister, 1.6 WTE nurses and 0.8 WTE.CSW.

Medical staffing

- The medical team at MSH comprised 1.4wte consultants, 1 WTE specialist registrar, 1 WTE foundation year 1 doctor, 1 WTE General Practice Vocational Training Scheme doctor and 0.4 speciality doctor provided medical care to the MSH.
- There was an advice line for use out of hours (during evenings, overnight and at weekends).

Major incident awareness and training

- Staff were aware of the trust wide policy.

Are end of life care services effective?

Good

We found that services at MSH were rated good for effectiveness.

Staff did not always obtain or record consent in line with relevant guidance and legislation. There was a lack of consistency in how people's mental capacity was assessed and not all decision-making was informed or in line with guidance and legislation.

Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. The staff identified expected outcomes and they regularly reviewed and updated care and treatment. The trust had replaced the Liverpool Care Pathway (LCP) with the Individual Care Plan (ICP.) The staff used the ICP to guide the care they gave.

End of life care

There was participation in relevant local and national audits, including clinical audits.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The trust had identified the learning needs of staff and training was in place to meet their learning needs. The trust supported staff to maintain and further develop their professional skills and experience. Staff were supported to deliver effective care and treatment, most staff attended meaningful and timely supervision and appraisal.

Evidence-based care and treatment

- The trust had replaced the Liverpool Care Pathway (LCP) with the Individual Care Plan (ICP.) It was relevant, based on current guidance, standards, best practice and legislation. It ensured that care and treatment were assessed, planned and delivered at end of life care in line with NICE 'Quality Standards and 'One Chance to Get It Right' document. We saw information leaflets and posters about the ICP in the ward.

Pain relief

- There was guidance for prescribing palliative medication and guidance for use of anticipatory medication at end of life, which provided guidance for pain relief. We saw appropriate anticipatory prescriptions including medication for pain relief at appropriate dosages with a rationale in the patient's records for patients using the ICP.
- The team used an hourly intentional rounding system. (Intentional rounding is a structured process where nurses on wards in acute hospitals carry out regular checks with individual people at set intervals, typically hourly. During these checks, they carry out scheduled or required tasks.) Pain relief was included in the hourly check.
- The team had developed a new pain assessment tool and care plan for people with cognitive/communication difficulties. The team had piloted it and carried out an audit at MSH. They had found it to be successful and planned that to share it with the rest of the trust.
- Staff told us syringe pumps were used to give a continuous dose of painkiller and other medicines were available to help with symptom control in a timely manner.

Equipment

- The National Patient Safety Agency (NPSA) recommended in 2011 that all Graseby syringe drivers should be withdrawn by 2015. McKinley syringe drivers had replaced Graseby Syringe Driver MS26 across the trust, following a comprehensive education programme for all nursing staff in September 2013. All new nursing staff received training on this equipment as part of their induction. On-going training was available to maintain competence and confidence in using the equipment.

Nutrition and hydration

- The ICP was used by staff to highlight and address nutrition and hydration needs at the end of life. Assessments incorporated patient choice, wishes and comfort and we saw ongoing nursing assessments included nutrition, hydration and mouth care needs. We observed nutritional assessments were completed. The nursing records such as nutrition and fluid charts were thorough and summarised accurately.
- We saw 'snack trolleys' in each bay. Staff told us these contained snacks chosen by the patients that they could access 24 hours a day. These were available to enhance nutritional needs.
- We saw nurses carried out nutritional screening. They recorded preferences and any assistance that might be needed. They referred the patients to a dietician if screening had identified concerns. There were snack trollies in each bay. The benefits of the snack trolleys were that patients said they freedom of choice at a time they wanted the snack.
- A dietician was available to give advice should it be required.
- There was a dining area; patients were encouraged to eat their meals together in the dining area if they were able to.
- Enteral feeds were used for malnourished patients or in those at risk of malnutrition who had a functional gastrointestinal tract, but were unable to maintain an adequate or safe oral intake. Enteral feeding referred to the delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach, duodenum or jejunum).

Patient outcomes

- Training in end of life care was now part of the trust's mandatory training.

End of life care

- There was evidence of guidance for prescribing palliative medication and evidence of guidance for use of anticipatory medication at end of life.
- During inspection we did not see evidence of work being done to ensure referrals that were more appropriate. The trust told us referrals to MSH were discussed at an MDT and only accepted if appropriate and had met set criteria. The referral coordinator recorded inappropriate admissions.

Competent staff

- Policies, procedures and guidelines were available to nurses, doctors and support staff who were able to access them when necessary.
- The SPCT had a folder on the trust's knowledge centre on the intranet which contained documents such as policies, standards for practice, referrals documents, and information about five priorities of care. In addition, there was information for patients and relatives and equipment information sheets. All staff had access to this information 24 hours a day seven days a week.
- We saw that the trust had implemented a programme to replace syringe pumps alongside training for staff on how to use the new equipment. All newly qualified nursing staff received training on this equipment as part of their induction. The trust provided evidence of staff who had received syringe driver training in 2015. We saw that three nursing staff at MSH had completed their training.
- There were two dementia link nurses. They acted as role models for providing good care for patients with dementia. They had attended additional training sessions to maintain competency for their role and they shared relevant knowledge, processes and skills to their teams.
- Staff we spoke with were competent and knowledgeable. They told us that they maintained their awareness of recent developments and by accessing information through training and self-directed study. The trust had a SPCT training service to assist staff in updating their knowledge. Staff told us that recently, due to increasing complexities of patients' needs, that it had become more difficult to release staff for training/ study days.
- Records showed that 75% of staff had undergone an appraisal. The staff we spoke with told us that they had participated in an appraisal in the last year. However, there were no records of supervision. The trust told us at the time of inspection, supervision had been suspended due to shortages of facilitators. However all staff could attend the monthly staff support group, run by the patient and family support team.

Multidisciplinary working

- MSH employed 1.8 WTE complementary therapist/ creative arts counsellors, 0.5 WTE occupational therapist, 0.64 WTE physiotherapist,1.0WTE therapy assistant and a 0.6 WTE chaplain.
- The MDT met formally every week to review any proposed new admissions. All reported a good working relationship with other professionals. There were formal links with GPs, community nurses and community MacMillan nurses.
- We observed a lunchtime nursing handover, it was clear and concise and we saw evidence of open discussion about patients' care. Furthermore there was discussion about timely referrals to appropriate professionals such as the chaplain, physiotherapist and community teams. The staff discussed and addressed patients' holistic and psychological needs.

Seven-day services

- There was an advice line for use out of hours (during evenings or overnight).
- MSH has its own rota system for out of hours. The rota system was covered by 1st on-call junior doctor, supported by 2nd on-call specialist palliative consultant. The on- call doctor covered a ward round every Saturday. On occasions where the specialist rota was short the MVCC medical team covered 1st on-call for MSH.

Access to information

- The DNACPR forms were stored at the front of patient's notes. They were easily identifiable and allowed easy access in an emergency.
- The ICP document stayed with the patient on discharge. The document was passed to the community team and ensured continuity. It contained information needed for the patient's ongoing care so that information was shared appropriately, in a timely way and in line with relevant protocols.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

End of life care

- Staff overlooked the need to adequately assess patients' mental capacity on occasions. For example in an attempt to reduce the numbers of patients falling at night, pressure sensor equipment was being used. (Pressure sensor equipment can reduce the risk of a patient falling, if trying to move without requesting assistance. A chair or bed sensor can be used to alert staff when a patient is mobilising independently, but has been assessed as unsafe to do so. An alarm is produced when the patient moves from the bed or chair). An assessment should be carried out to assess if the patient had capacity to agree to sensor use. If not, a best interest decision should be made, following discussions with the multi-disciplinary team and next of kin and recorded with reason for use of such systems stated. We did not see any evidence that discussions or assessment of capacity with regards to the use of the equipment with the patients, or those close to them, documented in the patients' notes. When this was raised with staff, they were not aware of the need to complete capacity assessments.
- We looked at five DNACPR forms we saw that in all of these forms there was, noted in their medical notes, discussion with the patient and where appropriate their next of kin.

Are end of life care services caring?

Good

People were supported, treated with dignity and respect, and were involved as partners in their care.

Feedback from people who used the service, those who are close to them were positive about the way staff treated people. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. People felt supported and said staff cared about them.

People were involved and encouraged to be partners in their care and made decisions, with support that they needed. Staff spent time talking with patients and those close to them. They were communicated with and received information in a way that they could understand. People understood their care, treatment and condition.

Staff responded compassionately when people needed help and supported them to meet their basic personal needs as and when required. They anticipated people's needs. People's privacy and confidentiality was respected at all times.

Staff helped people and those close to them to cope emotionally with their care and treatment. People's social needs were understood. People were supported to maintain and develop their relationships with those close to them. They were enabled to manage their own health and care when they could, and to maintain their independence.

Compassionate care

- The team told us they provided emotional care along with practical support for patients and those close to them. They said the MSH team aimed that; "Every patient should experience a journey towards the end of their life that was peaceful, comfortable and free from worry and pain."
- Patients we spoke with were complimentary about the care that was provided. One patient we spoke with said; "Being here was like being wrapped in a warm blanket". Another patient told us that call bells were answered within seconds and that staff checked on their wellbeing all the time. They said that staff had discussed and addressed their pain relief needs. One patient said: "They treat me like a human being; it makes me a bit tearful when I think how kind they have been to me". Patients told us that staff were courteous and treated them with dignity and respect. "The care is so good; you wouldn't get it in a hospital".
- We observed staff responding compassionately when people needed help. Staff supported patients to meet their basic personal needs when required. They anticipated patients' needs. Staff maintained patients' privacy and confidentiality.
- Relatives gave us positive feedback about the care that was provided. One relative we spoke with said that the care provided was; "Second to none," that they; "Couldn't fault it." They told us that they had been visiting the hospice for weeks; they felt the care was; "Consistent and genuine".

End of life care

- There was open visiting. Staff and relatives told us that relatives could come at any time of the day or night to visit their relative and stay as long as they wanted. Staff ensured that relatives had access to food and drinks 24 hours a day whilst they were visiting.
- There was a 'memory book' in the multi faith room, which contained messages written on behalf of bereaved relatives. The room was suitably decorated, clean and bright. It was, however, next to the cooling room and as a result it was cold and noise from the cooling unit could be heard.
- The chaplaincy team visited and provided support. Staff alerted the chaplaincy team if a patient had requested to see them. Staff we spoke with told us that the chaplaincy team were helpful and easy to access. At the time of inspection, the chaplain post was vacant; the Lister Hospital Chaplaincy team had provided support. A chaplain was due to start week commencing 26 October 2015.
- The chaplaincy team had access to contacts in the community for support for other religions.
- There was a lounge, garden and an aviary, which were accessible to patients and those close to them. Patients and relatives used these areas as an alternative visiting space or as a space to have time to themselves.
- There were information leaflets available to patients and families, including advice on managing symptoms and on financial matters.
- Emotional and psychological support was available to patients and families through the patient and family support team.
- During a nursing handover, we saw evidence of the team using a holistic approach. We saw the staff using a pain chart to help to establish a pattern in the patient's pain presentation and how this could be managed to enable them to carry out their activities of daily living such as personal care. The team aimed to identify when to administer pain relief so that it was timely and ensured the patient could maintain their independence in completing tasks.
- MSH held a number of social events such as barbeques and talent nights, for patients and those close to them, to attend.
- MSH had a number of volunteers who provided services such as complementary therapies. Complementary therapies were used by some patients alongside, or in addition to, conventional medical treatments to boost their physical or emotional health or to relieve symptoms or side effects.
- The trust did not collect information of the percentage of their patients who died in their preferred location. Specialist Palliative Care MDT South West Herts, collected information on the percentage of patients from the region who were discharged to their preferred place of death. This information was fed back to the SPCT meeting. Without specific information, the trust was unable to monitor if they were honouring people's wishes and if work was needed to improve this.
- The trust did not collect information of the percentage of people who achieved discharge to their preferred place within 24 hours. Without this information the trust was unable to monitor if they were honouring people's wishes and if work was, need to improve this.

Understanding and involvement of patients and those close to them

- Staff told us that there were car-parking concessions available for relatives spending long periods at MSH. They could purchase weekly and monthly parking tickets at a reduced rate.

Emotional support

- During a nursing handover, we saw evidence of the team considering a patient's psychological needs by referring a patient to the patient and family support team.
- Patients and those close to them who utilised MSH could access the patient and family support team. This team provided support for psychological and social difficulties. Support was offered through counselling and a range of expressive therapies.
- A team of twelve bereavement counsellors supported the families and friends of patients who had died whilst under the care of Michael Sobell Hospice. They made contact approximately one month after the person had died and counselling was offered. They provided a number of different services from a one-off telephone contact or single session, to a fixed number of sessions. Bereavement counsellors saw people in Michael Sobell Hospice in its dedicated counselling room.

Are end of life care services responsive?

End of life care

Requires improvement

Patients' needs were not always met as services were not always organised and delivered to meet the needs of the local population.

Information about referral data was not formally monitored by the trust at the time of our inspection.

Data was not collected about patients' preferred place of death and whether this had been achieved.

Care provided was flexible. Patients were given choices and continuity of care. Staff considered patients' needs when services were delivered.

People's discharge or transition plans took account of their individual needs, circumstances, ongoing care arrangements and expected outcomes. People were discharged at an appropriate time and when all necessary care arrangements are in place.

Care and treatment was coordinated with other services and other providers the team at MSH had good links had good working relationships with their community colleagues which ensured that when people were discharged, their care was coordinated.

Service planning and delivery to meet the needs of local people

- The team told us they managed between two and seven admissions per week and on occasions admission was not possible due to staffing issues. The team were auditing this. The hospice had carried out a snap shot audit of their referrals in September and October 2015. This showed that out of 39 referrals 12 people were admitted on the same day as referral. Reasons for non-admission were recorded, but during inspection we did not see any evidence that there was no action plan in place to assess risk if a patient could not be admitted. Post inspection the trust told us all patients were assessed regarding risks if patients were not admitted. This was part of the triage process and would be discussed with the referrer. Advice would be offered and either day care or outpatients considered if appropriate. They told us there were many occasions when MSH had admitted patients at weekends (when Friday admission has not been possible); the use of local services such as hospice @ home & Marie Curie nurses was employed until admission was possible.

Meeting people's individual needs

- We saw evidence of individualised symptom management. Staff used the IPC to assist with their assessment of patients' needs.
- We saw evidence that the staff were aware of patient's holistic care needs. We saw the staff using a pain chart to help to establish a pattern in their pain presentation and how this could be managed to enable them to manage the activities of daily living, such as personal care.
- The staff were aware of the needs of patients with cognitive difficulties and had identified a piece of equipment to allow relatives to record a message that could be played to the patient on the occasions they became distressed and in need of reassurance. A charity had funded the purchase of an electronic tablet to assist with this method of communication.
- The team had developed a new pain assessment tool and care plan for people with cognitive/communication difficulties. It had been piloted and subsequently audited at MSH. They had found it to be successful and planned to share it with the rest of the trust.
- The team were involved in service specific audits. They were encouraged to identify issues they came across and see if they could improve a situation. For example, the nurses at MSH felt their night-time duties hindered patients' ability to get a good night's sleep. The nurses undertook an audit to recognise what factors disturbed patients during the night and identified some areas to improve the quality of rest that patients had. For example, prescribing of anticipatory medicines and prophylactic use of analgesia at night, offering pre-lights out snack/drink and facilitate routine toileting of patients before retiring to bed/sleep. The staff said that it was reassuring to know that nurses and their duties did not appear to be a cause of sleep disturbance.
- There were two dementia link nurses. They acted as experts/role models for providing good care for people living with dementia.

End of life care

- There was a multi faith family room, which was open and accessible to all, 24 hours seven days a week. Family and carers used the room to view their recently deceased relatives or as a space to have time to themselves.

Access and flow

- We did not see a system or process for triaging referrals. Staff we spoke with said there was no triage system in place. However the trust told us that all patients were triaged at the weekly bed meeting or on a daily basis with the referrals coordinator, nurse and consultant.
- Referrals to the service were made by phone, fax or email directly to the referrals coordinator or the nurse in charge, out of hours.
- Urgent referrals were discussed with the team on an individual basis; however, generally referrals were taken to a weekly multidisciplinary meeting, which were held on Mondays. Staff told us that referral information had been collected for several years but nothing formally had been done with the information by the hospice or the trust. The trust told us referral outcomes information was discussed on a weekly basis by the MDT at bed meetings and an audit of outcomes was presented to the MSH clinical governance meeting
- The team told us the unit had 279 admissions in the last year. Bed occupancy was 80%, the average length of stay was 11 days.
- The team told us they managed between two and seven admissions per week and on occasions admission was not possible due to staffing issues, for example, insufficient trained staff. The team were auditing this in an effort to be able to identify improvements to enable the hospice to be more responsive to patient's needs.
- The SPCT had implemented a rapid discharge process to support people to be discharged at an appropriate time and when all necessary care arrangements were in place. The MSH team used this process when required. If equipment such as a bed was required, the team liaised with the district nurses in the patient's home area to arrange delivery. Standard bed delivery was five days so timely identification of equipment needs was important.
- The trust did not collect information of the percentage of people who achieved discharge to their preferred place within 24 hours. The SPCT told us occasionally discharges were delayed due to difficulty in commissioning services, such as available community care packages or transport.
- Staff we spoke with told us all referrals and their outcomes were recorded on the 'Referral Sheet'; this information had been collected for several years but nothing formally had been done with the information by the hospice or the trust.
- The team discussed the referrals at a weekly multidisciplinary meeting. Urgent referrals were discussed on an individual basis.
- Since September 2015, the MSH team had carried out an internal audit of the reasons for delays in admission and/or reasons why some patients were not admitted, by using a spreadsheet to record data. The categories 'emergency', 'urgent' and 'planned' were based on discussion with referrer at the time of request.
- The hospice carried out a snap shot audit of their referrals. This showed that in September and October, out of 39 referrals 12 people were admitted on the same day as referral. Reasons for non-admission were recorded as:
  - In eight patients, the request was withdrawn.
  - Seven people died before admission date.
  - Six did not have specialist palliative care needs.
  - Six were termed as multi-activity (referred to more than one place).
  - Five were not admitted due to staffing or dependency issues, for example, patient needed 1:1 care and there were insufficient staff, and/or the patient needed hi-flo oxygen.
  - Three had called emergency services and were admitted to general hospital before admission and
  - Two were so near the end of their life, it was too late to transfer them.
- The audit showed that 29% of patients referred, were not admitted. There was evidence that some patients were dying at home, calling 999 and/or being admitted to a general hospital. The team were in the process of completing an action plan to address the fact that patients could not always be admitted to the hospice once they were referred.

Learning from complaints and concerns

- MSH did not receive any formal complaints in the last year.
- We saw letters and cards of thanks from relatives/carers.

Are end of life care services well-led?

End of life care

Requires improvement

The leadership, governance and culture did not always support the delivery of high quality person-centred care.

The vision and values were not well developed and we did not see evidence that staff were aware of the trust's vision or strategy.

Risks and issues were not always dealt with appropriately or in a timely way. The risks and issues described by staff did not correspond to those reported to and understood by leaders.

Staff did not always raise concerns. Staff at all levels were unaware of the potential risks associated with the safety issues raised.

There was evidence that the service sought the views of people who used services and other stakeholders.

The approach to service delivery and improvement was reactive and focused on short term issues. Improvements were not always identified or action not always taken. Where changes were made, the impact on the quality of care was not fully understood in advance or was not monitored.

Vision and strategy for this service

- We saw no evidence of cross working with the Lister SPCT.
- We did not see any evidence that the staff at MSH were aware of or involved in the trusts vision or strategy.
- The trust EoLC strategy covered both sites and included issues at MSH
- The staff were focussed on providing good quality care for their patients.

Governance, risk management and quality measurement

- The head of palliative care attended the Cancer/ Palliative Care Service Clinical Governance Meetings, the SPCT meetings and the MVCC SPC Strategy Group meeting. Information from these meetings was fed back to the MSH teams at head of department meetings, MSH clinical governance meetings and at departmental meetings.
- The trust did not collect information of the percentage of people who were discharged to their preferred place within 24 hours. Without this information, the trust were unable to monitor if people's wishes were being honoured and if work was required to improve this.
- The consultant in palliative medicine and the head of palliative care attended monthly governance meetings within the medicine directorate where governance issues were discussed and addressed.
- The long standing risks found at inspection, for example poor maintenance and lack of monitoring, (out of date medication) was not included on the trust's risk register. This demonstrated a lack of oversight. The trust told us Michael Sobel House (MSH) did not have an independent risk register. Any risks identified were added to the Mount Vernon Cancer Centre (MVCC) risk register. We saw that whilst maintenance issues were included on the MVCC risk register MVCC site risk. "patient care was compromised due to poor fabric of the estate at MVCC" it did not detail specific areas of concern.

Leadership of service

- The hospital's senior leadership team were well known to all the staff.
- There was palliative care lead in post who spent half of their time at MSH and the other half at The Lister Hospital. Day to day, the ward sister had responsibility for the unit. Although staff we spoke with were aware of who their immediate managers were and said they were helpful and supportive, there was a lack of strategic oversight which had led to inconsistent systems, processes and standard operating procedures.

Culture within the service

- The MSH staff we observed were respectful and maintained patients' dignity, there was a person centred culture. We saw staff responding to patients' wishes.

Public engagement

- The hospice participated in the FAMCARE survey. (FAMCARE was a national survey of the quality of end-of-life care, which was organised by the Association for Palliative Medicine of Great Britain and Ireland. The aim of the survey was to see how each service was doing in the care of patients referred to palliative care services). At the time of the inspection the trust told us that the recent FAMCARE survey was not available.

End of life care

- The service contacted all patients who were discharged to check that patients were happy with the care/ discharge arrangements.
- A year long carers survey was completed and MSH were part of a locality MDT survey regarding SPC services.

Staff engagement

- Staff were invited to attend monthly departmental meetings. These meetings were used to raise issues and or concerns and feed into the MVCC clinical governance meetings.

Innovation, improvement and sustainability

- There was a strong focus on research. The research and audit nurses encouraged all members of the team to be involved in service specific research. They were encouraged to identify issues they came across and see if they could improve the situation. We saw a number of posters that had been presented at national conferences. This meant that the team looked for opportunities for what they could do to improve the care they provided.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient appointments are available Monday to Friday between 9am and 5pm.

Almost 90,000 patients were seen in the department during 2014 of which 66% were follow up appointments and 18% were new patients. Four per cent of patients appointments were cancelled by the hospital and five per cent were cancelled by the patients themselves. Seven per cent of patients did not arrive for their appointments, all of which is similar to the England average.

During our inspection we spoke with 15 patients along with two of their relatives. We also spoke with eight members of staff including the deputy general manager for cancer services, reception and booking staff, nursing staff and health care assistants.

Summary of findings

There was a clear process for reporting and investigating incidents, and learning from incidents took place.

The cleanliness and hygiene in the departments was within acceptable standards. Personal protective equipment was readily available for staff and was disposed of appropriately after use.

Staff were aware of their role in safeguarding, a reporting process was in place and staff knew how to escalate concerns

Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal.

Staff obtained written and verbal consent to care and treatment which was in line with legislation and guidance.

Patients received a caring service. Patients were treated with dignity and staff were kind, respectful and supportive. Staff gave clear explanations of treatments and most patients were confident about the care they received. Patients and their relatives were positive about their experiences of care and kindness offered to them. Patients told us that they were involved in decisions about their care and treatments and were given appropriate information.

Outpatients and diagnostic imaging

There was a strong leadership team in the Mount Vernon Cancer Centre. The Cancer Management team were recognised by everyone we spoke to as being highly effective. This was highly valued by members of the clinical team. The executive team were less visible in non-clinical areas. There was a positive culture; staff felt engaged in (and part of) the Mount Vernon Cancer Centre.

There were strong governance systems in place. Review of information and audit supported management actions. Regular Quality Improvement Team meetings were held. We saw evidence of their impact.

There was clear evidence of both staff and patient engagement in service provision and development.

Are outpatient and diagnostic imaging services safe?

Good

We rated safety in outpatients as good because:

Incidents were reported using the hospital's electronic reporting system. Incidents were investigated and lessons learned were shared with all of the staff.

The cleanliness and hygiene in the departments was within acceptable standards. Personal protective equipment was readily available for staff and was disposed of appropriately after use.

Staff were aware of their role in safeguarding, a reporting process was in place and staff knew how to escalate concerns.

Medical records were stored securely and were available for outpatient clinics.

Incidents

- There were processes in place for reporting of incidents and there were opportunities for staff to receive feedback and lessons learnt via staff meetings, MDT meetings and staff room notice boards.
- The hospital reported that there had been no incidences of a never event, in the reporting period July 2014 to June 2015. A never event is a serious incident that is 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.
- We reviewed incidents hospital wide and saw that there were no serious incidents relating to the outpatients department. The incidents we saw had been investigated thoroughly and related to clinics that had run over the allocated time, or medical information, such as scans, missing from a patient's notes. We saw that there had been some initiatives to minimise waits. However, these had minimal impact and was reported to us to be: 'Ongoing work in progress.'
- All staff we spoke with understood their responsibilities with regard to the Duty of Candour legislation.

Cleanliness, infection control and hygiene

Outpatients and diagnostic imaging

- Outpatient clinic areas were visibly clean and tidy.
- There was personal protective equipment (PPE) available and hand washing facilities in each clinical room. Staff across the department were seen to be using PPE appropriately.
- 100% of staff across OPD had completed mandatory infection control training.
- There were posters in waiting areas and other communal areas advising patients to use hand gels.
- 'Productive ward' noticeboards displayed infection control and hand hygiene audit outcomes. This showed compliance across outpatient services was between 97 – 100%.
- During our inspection we observed correct systems for waste disposal, including sharps. Waste bins were emptied regularly and not overflowing.

Environment and equipment

- All areas appeared clean. However, the building was old and required updating and refurbishment.
- Resuscitation equipment was checked daily, and documented as complete and ready for use.
- The patient-led assessment of the environment (PLACE) survey score for the hospital was 98% for cleanliness, 95% for food and 98% for privacy and dignity in 2015. We saw a specific action plan following the PLACE audit to ensure improvements were made.

Medicines

- We checked the storage and management of medicines and found effective systems in place. No controlled drugs were stored in the outpatients departments. Small supplies of regularly prescribed medicines were stored in locked cupboards and, where appropriate, locked fridges. We saw the record charts for the fridges which showed that the temperature checks were carried out daily and that temperatures were maintained within the acceptable range. All medicines we checked were in date.

Records

- We looked at eight patient records in OPD. We saw evidence in the records that patients' consent for treatment had been gained. Records were legible and updated.
- We observed that medical records in use in the two outpatient clinics running on the day of our visit were stored securely.
- A combination of paper medical records and an electronic system where diagnostic imaging, pathology and microbiology, diagnostic results were stored, was used in the department.
- A senior staff member told us that it was very rare that records were not available for an appointment. We were told that there had only been one occasion in recent years where a temporary file was prepared for the patient that included correspondence and diagnostic test results so that their appointment could go ahead. This meant that the patient did not have to reschedule their appointment and the temporary file was merged with the main file once it was located.

Safeguarding

- Staff we spoke with understood their responsibilities for safeguarding and knew what to do if there was a concern.
- The process was managed through the records kept by Human Resources (HR) and staff were advised by HR when they required refresher training.
- Records showed that 100% of staff had completed adult safeguarding training.
- Safeguarding training for children level 1 and level 2 was 100%.

Mandatory training

- Mandatory training was monitored and managed through the HR department. The system was efficiently and effectively managed.
- Alerts were raised when a member of staff was due for a training update. Staff received a personal email reminder from HR when training was due. Staff engaged with this system well.
- We reviewed the training records held by the senior sister in OPD and this showed that there was 100% compliance with mandatory training.

Assessing and responding to patient risk

- Patients were given written and verbal information with regards to alerting them to the risk of and the symptoms of neutropenia (low white cell count) whilst they were undergoing chemotherapy.

Nursing staffing

- The OPD staffing team comprised five nurses (10.5 whole time equivalent (WTE)) and 4 WTE clinical support workers (CSWs).

Outpatients and diagnostic imaging

- OPD had one vacancy for a staff nurse. However, recruitment had been undertaken to fill this position.
- There was a local induction process in place for bank and agency nurses, the induction consisted of a checklist used to ensure temporary staff were familiar with the environment they were working in. However, agency staff were rarely used.

Medical staffing

- There were a number of specialities that worked within the department and medical staff of various grades worked within their particular specialities within the clinics.
- Medical staff undertaking clinics were of all grades, however on the day of our visit we saw that there were consultants available to support lower grade staff when clinics were running.

Major incident awareness and training

- A senior manager spoken with confirmed that they were aware that there was a major incident plan available on the trust's intranet.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal.

Staff obtained written and verbal consent to care and treatment which was in line with legislation and guidance.

Evidence-based care and treatment

- Staff reported that clinical policies and guidance were available on the hospital intranet.

Pain relief

- During our inspection, we did not see patients in distress or requiring pain relief. A staff member told us that they visibly check patients every 30 minutes to ascertain if they are in pain or uncomfortable.

Patient outcomes

- No treatments were carried out in the department, apart from injections and minor dressings. Some patients were recruited onto clinical trials from the outpatients department; however, their outcomes were not part of the outpatients programme.

Competent staff

- An induction plan was in place for all new staff to gain competencies for their job role. Continual professional development was promoted in the departments. Staff were encouraged to widen their understanding of different aspects of the service. Staff told us they were able to identify specific learning through the appraisal process.
- Specialist nurses worked within the outpatients department alongside medical colleagues, although there was a shortage of specialist nurses in some tumour types.
- We spoke with the tissue viability link nurse for OPD. They had attended additional training sessions to maintain competency for their role and they shared relevant knowledge, processes and skills to the OPD team.
- Information provided by the trust showed that 100% of OPD staff had undergone an appraisal within the last year.
- There was no formal clinical supervision for nursing staff.

Multidisciplinary working

- Staff we spoke with reported that they worked well with all the multidisciplinary team (MDT), including doctors, therapists and social workers. We did not observe any MDT meetings during our visit.

Seven-day services

- The outpatients department was open from 9am to 5pm, Monday to Friday. Staff told us they often worked after 5pm if necessary to ensure that all patients were seen.

Access to information

- Staff told us they had good access to patient related information and records whenever required. This meant that staff had access to the information which enabled them to care for patients appropriately.

Outpatients and diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had an up to date consent policy that staff were familiar with. The hospital consent forms complied with Department of Health guidance.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people.
- Staff were unclear with their responsibilities with regards to Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). However, they said they would seek advice if necessary.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring in outpatients as good because:

Outpatient services were delivered by caring and compassionate staff. We saw numerous examples of patients being treated with dignity and respect, and given compassionate care.

Patients told us that medical and nursing staff answered their questions and kept them informed of their care and treatment.

Compassionate care

- Throughout our inspection we saw patients being treated with dignity and respect.
- Patients gave positive feedback about the staff.
- All consultations took place in a private room to protect patients' privacy.
- Receptionists spoke with patients in a polite way.
- Within the OPD service the Friends and Family Test (the proportion of patients willing to recommend the service as good to friends and family) was 96% for September 2015, although this was trust wide data.

Understanding and involvement of patients and those close to them

- Patients spoken with felt well informed and included in decision making in relation to their care and treatment from start to finish.
- Patients were aware of who to contact if they were concerned about their appointments and contact details were available on their appointment letters.

Emotional support

- Staff said they were all sensitive to the emotional needs of patients and we saw patients being treated with kindness.
- Patients were positive about the support they received from staff within the outpatients department.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsiveness in outpatients as requires improvement because:

There was always a long wait to check in at OPD.

Clinics regularly over-ran and some patients had to wait a long time to be seen by medical staff.

Staff had training to care for patients living with dementia. There were links to access special care for patients with a learning disability.

Service planning and delivery to meet the needs of local people

- There was a large main waiting area and a smaller sub waiting area for specific clinics.
- We noted that there were no chairs to suit people's needs, for example higher chars for patients who were less mobile. The chairs were placed to maximise numbers of seats and did not consider patient's comfort. All the chairs were hard and looked uncomfortable, particularly as the waiting times were so long.
- We saw long queues in the outpatients department and down a main corridor for patients to be checked in. This happened at all times of the day. Staff told us there should always be two receptionists to ensure that patients were dealt with quickly, telephones answered promptly and patients' notes obtained. However, there was only ever one, with a reliance on volunteers to fill gaps.

Access and flow

Outpatients and diagnostic imaging

- Waiting times for patients upon arrival in the outpatient clinics varied. Patients said they often waited a number of hours in the hospital to see the consultant or for diagnostics to be carried out.
- During our inspection, we saw clinics were not running on time. Staff told us that there had been occasions where patients had had a two hour wait for their appointment. They confirmed that they would escalate this to the matron and complete an incident form.
- Staff told us that patients were informed if clinics were running late. Patients were informed of the reason for the delay and approximate time they would be seen. On the day of our visit we saw staff inform patients, apologise and explain why clinics were running late.
- Staff were unable to provide us with data regarding the percentage of patients waiting more than 30 minutes to see a clinician as they did not collect this.
- A staff member explained that the OPD were trialling 'intentional rounding' for patients waiting a long time for their appointment. This involved a staff member checking patients' environment, waiting time, personal wellbeing and staffing at set times during the day. The results of any audit of the intentional rounding system were not available at the time of our visit.
- The number of follow up appointments compared with first appointments influences how many newly referred patients can be seen and meet the waiting times standards. A lower ratio improves patient flow. Follow up to new appointment waiting time rates for Mount Vernon Cancer Centre ranged between 6-11%, which is higher than the England average of 2.5%.

Meeting people's individual needs

- Staff reported that they were able to access translation services for patients whose first language was not English. Staff could book interpreters to attend the outpatient clinic or alternatively use telephone access.
- The senior sister reported that staff had received training to support people living with dementia. They said that staff would ensure any patient who had particular needs would be given extra assistance and their appointment would be prioritised.
- The hospital had links with the specialist Learning Disability (LD) team at The Lister Hospital, who provided support when needed. There was no nominated link nurse within the OPD; however staff told us they could contact their colleagues on the inpatient wards for advice if necessary. The staff told us that they made adjustments and provided extra support for patients with a learning disability, for example, their clinic appointment time would be prioritised so that they did not have to wait.

Learning from complaints and concerns

- Patients were encouraged to comment on the care they had received.
- There was a leaflet available to patients (called Comments, Compliments, Concerns, Complaints) which included all feedback options for patients within one leaflet.
- We saw that the service encouraged patients' comments and complaints.
- We also saw that the trust encouraged local resolution of concerns by staff before the escalated into a formal complaint.
- Cancer Services had seen a reduction in formal complaints from 47 in 2013/14 to 33 in 2014/15. Data was not available for the outpatients department specifically.
- We did note that the proportion of complaints responded to in the agreed time had fallen (worse) from 74% in 2013/14 to 47% in 2014/15.

Are outpatient and diagnostic imaging services well-led?

Good

Outpatients was well led because:

The outpatients leadership team was good.

In addition, the Cancer Management team were recognised by everyone we spoke to as being highly effective. This was highly valued by members of the clinical team. The executive team were less visible in non-clinical areas. There was a positive culture; staff felt engaged in (and part of) the OPD service within Mount Vernon Cancer Centre.

There were strong governance systems in place. Review of information and audit supported management actions. Regular Quality Improvement Team meetings were held. We saw evidence of their impact.

There was clear evidence of both staff and patient engagement in service provision and development.

Outpatients and diagnostic imaging

There was a lack of oversight and action to minimise long waiting times in the department.

Vision and strategy for this service

- The trust had a single vision to 'be among the best'. This was underpinned by three trust wide strategy elements, one of which was to focus on the development of the OPD service. The other two strategy elements were; 'keeping promises on value and quality' and 'new services and ways of working through partnerships.'
- We saw a strong leadership team for the OPD with a unified vision of the requirements for the future. We were unable to see this articulated as a single plan with trust wide sign off.
- The land that Mount Vernon Cancer Centre was built on was owned by another trust and leased by East and North Herts NHS Trust. The management team told us that key to their longer term strategy for the site, they had been working at trust level to renegotiate the lease to allow ownership of the site to change to East and North Herts NHS Trust. This would allow the development of the site to be driven by the East and North Herts NHS Trust. Staff told us there had been much discussion about building a new cancer centre but no definite decision had been made.
- We saw the trust brief to staff (September 2015) sent electronically, that updated staff on the latest position. It was clear from this, and from our discussions, that much work was being undertaken to resolve this issue.
- The management team were fully aware of the hospital's catchment area. The very large geographical catchment meant that patients had long travelling distances and times. However, this was not always considered with regards to scheduling and waiting times.

Governance, risk management and quality measurement

- Monthly management meetings were held. At these, complaints were reviewed and considered. Both responses to complaints and the themes and trends were discussed. We looked at the responses that the service had made to patients complaints. We saw that they were well considered and that the service responded appropriately.
- The service held monthly management meetings where incidents were discussed. Trends in incidents were also examined. Action plans were discussed and agreed. Following the meetings, emails were sent to the teams to share lessons and actions with them. Staff we spoke with were aware of any lessons learnt from their department, which mainly involved keeping patients informed with regards to waiting times. There seemed to be an acceptance that patients would have to wait for their consultation.
- There was no separate risk register, however, risks surrounding the environment which impacted on patients were recorded on the trust's risk register.

Leadership of service

- There was a good leadership team in the OPD service. In addition, the Cancer Management team were recognised by everyone we spoke to as being highly effective and they were highly valued by members of the clinical team. The trust executive team were less visible in non-clinical areas.
- There was a positive culture; staff felt engaged in (and part of) the OPD service within the Mount Vernon Cancer Centre. We observed ward managers and consultants on the wards and that they knew the staff. Ward managers and sisters reported they had a lot of support for their senior manager.
- All the senior staff we met were enthusiastic and motivated and wished to ensure that the patients received the very best care.
- It was clear that the senior staff, many of whom had been working at the hospital for some time, were supportive of each other. All the staff we spoke with spoke highly of the senior nursing team.

Culture within the service

- Staff described the OPD as good places to work and some had worked at MVCC for many years.
- The hospital had a large team of volunteers who supported the hospital in most departments. They supported various receptions providing a meet and greet service, preparing refreshments, working in all departments as assistants, running activities and fundraising. The volunteers were seen as an integral part of the team.

Public engagement

- Thank you cards were displayed on notice boards; comment cards were available for patients and any visitors to make comments on.

Outpatients and diagnostic imaging

- There was a patient experience committee that was held regularly. This was chaired by a non-executive director. A member of staff from the OPD was part of the group. It included six patient representatives and considered comments and complaints received by the services.

Staff engagement

- Staff were invited to attend monthly departmental meetings. These meetings were used to raise issues and or concerns and feed into the MVCC clinical governance meetings.
- Communication to staff was through regular newsletters via e-mail.

Innovation, improvement and sustainability

- There was a clinic pharmacist who worked within the OPD. This meant that any medicines issues were responded to quickly and included managing medicines of patients attending for radiotherapy.

Chemotherapy

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

Information about the service

The chemotherapy Suite (CHS) and Marie Curie Day Unit (MCDU) both deliver outpatient chemotherapy Monday to Friday and some Bank Holidays. MCDU has 16 chairs and 3 beds and CHS has 20 chairs and 2 beds. Some of the chairs are allocated for clinical trials but work is covered by CHS staff unless it is Phase 1 work which is done by the research nurses. Approximately 290 patients a week are treated in the three units.

The Lister Hospital, Stevenage has an 18 chair chemotherapy suite which treats 220 patients a week.

Patients from all tumour groups are treated in the cancer centre's chemotherapy outpatients suite where they receive both simple and complex cytotoxic drug regimens and targeted therapies.

The chemotherapy service has a strong reputation nationally as a major contributor to clinical trials.

In addition there were two inpatient wards, 10 and 11 at MVCC, which have 45 beds between them. These were used to care for patients who were unwell as a result of their treatment and required in patient treatment, or for those on chemotherapy regimes that required an overnight stay.

Summary of findings

Staff understood their responsibilities to raise concerns, record and report safety incidents, and near misses, and to report them internally and externally, although learning from incidents and complaints was limited.

All areas appeared clean. The chemotherapy areas were bright, modern and welcoming, despite the building being old and required updating and refurbishment.

Although the hospital gathered and analysed patient information such as hospital acquired infections and reviewed these through its clinical governance processes, there was no oversight of urgent transfers. Infection rates were low. There had been no reported incidents of MRSA or C Diff. in the two years prior to our inspection. Clinical waste was disposed of safely. This included chemotherapy waste. There were arrangements in place for managing medicines, including chemotherapy and radioactive substances to keep people safe.

Generally the hospital was adequately staffed. Mandatory training rates for all staff were at 90% which was the hospital target.

There was a process in place to obtain rapid treatment for patients who were suspected of having neutropenic sepsis. The East of England Cancer Network audit results for the whole network showed only 30% of

Chemotherapy

patients received antibiotics in two hours. However, the data from MVCC analysed separately, showed that 82% of patients received antibiotics within one hour and 91% within two hours.

There was a procedure in place to minimise chemotherapy being given via the incorrect route.

The hospital took part in local, trust and national audit programmes. Audits were undertaken of patients records each month were audited against compliance with assessment tools and care bundles.

The hospital was meeting the 31 day target for treating patients who required chemotherapy and radiotherapy for most tumour types.

All the consultants specialised in treating one or two tumour sites only. We found that there was a strong culture of multidisciplinary working between nurses, specialist nurses, doctors, allied health professionals and social workers.

None of the staff we spoke with had received training about the Mental Capacity Act 2005 (MCA).

Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Patients and relatives were well supported and were given as much or as little information as they wanted. Staff often went out of their way to ensure patient care went beyond their remit as healthcare professionals.

There were almost always long queues in the outpatients department prior to their chemotherapy, for patients to be registered, although patients who were nervous, for example, if they were needle phobic, were seen and reassured as soon as possible. There were always long waits for treatment, whether the patient chose to have a one stop option, or blood tests on one day and treatment the next. Patients who required daily treatment, but did not need an in-patient bed, were able to stay in the hospital's on-site hostel.

Patients often needed to go outside the main building to access other services. Often their individual needs were not always met with regards to keeping warm and dry.

Patients who required specialised treatment by a plastic surgeon for extravasation, needed to be transferred off site.

The service to insert Peripherally Inserted Central Lines (PICC) operated three days per week. This meant patients sometimes had their first treatment without the PICC line in situ.

There were links to access special care for patients with a learning disability. Staff had not had any training to care for patients with dementia.

The ratio of compliments far exceeded the complaints. However, we found that not all complaints, particularly verbal complaints were recorded.

Although each division within the hospital had local objectives and there were divisional objectives, there was no principal cancer strategy, nor was there a director with sole responsibility for cancer. There was no strategic oversight of the chemotherapy service.

Some staff were aware of the trust's vision. There was a plan in place to be autonomous from Hillingdon NHS Trust. All the medical staff had a Thursday afternoon at MVCC which included time in their job plan to attend the weekly Clinical Governance or Departmental Meetings.

All the staff we spoke with were proud to work for the Cancer Centre and would want their friends and family to be treated there should the need arise.

Chemotherapy

Are chemotherapy services safe?

Good

We have rated the care and treatment that people received as good because:

People were protected from abuse and avoidable harm. Staff understood their responsibilities to raise concerns, record and report safety incidents and near misses, and to report them internally and externally. We reviewed a sample of incidents and saw that they had been investigated thoroughly.

All areas appeared clean. Infection rates were low. However, the building was old and required updating and refurbishment. There had been no reported incidents of MRSA or C Difficile in the two years prior to our inspection. The hospital gathered patient information such as hospital acquired infections and reviewed these through its clinical governance processes, however, when patients were transferred out of the hospital for urgent treatment, there was no central monitoring and therefore no trend analysis or evidence of learning. The trust told us that in response to the concerns raised during the inspection, oversight had been improved through the introduction of a transfer follow up book which allowed updates to be recorded and monitored.

Clinical waste was disposed of safely. This included chemotherapy waste.

There were arrangements in place for managing medicines, including chemotherapy and radioactive substances to keep people safe. Chemotherapy was manufactured on site, on a named patient basis, aseptically, (in a germ free environment) by an external provider. There was sufficient equipment, for example intravenous pumps and subcutaneous drivers, to maintain safe and effective care.

There were systems in place to make safeguarding referrals if staff had concerns about a vulnerable adult.

Mandatory training rates for all staff were at 87% against a hospital target of 90%.

This was a procedure in place to minimise chemotherapy being given via the incorrect route.

Generally the hospital was adequately staffed.

Incidents

- Staff understood their responsibilities to raise concerns, record and report safety incidents, and near misses, and to report them.
- There was a hospital incident policy in place, which staff knew how to access. Staff told us they knew how to report an incident on the hospital's electronic system, although many of them said they did not receive feedback on incidents they had reported.
- The hospital reported that there had been no incidences of a never event, in the reporting period July 2014 to June 2015. A never event is a serious incident that is 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.
- The hospital reported 581 incidents during between September 2014 – August 2015, of which 541 had been rated low or very low and two of which were rated as serious. There was no separate category for chemotherapy incidents. Of the serious incidents, one was non-clinical and did not require analysis due to its nature. However, it was clear the other serious incident had been fully investigated and the family of the patient had been kept updated, including a meeting with the senior hospital staff. There had been a change of procedure put into place to ensure the incident was not repeated. Several senior staff described this incident to us during our inspection, which meant there was awareness and there had been learning.
- Senior staff had all undergone root cause analysis training and described a culture of learning from incidents. We saw an example of where there was trust wide change in practice, which originated from MVCC with regards to the supply of a particular medicine dose.
- We reviewed a sample of incidents and saw that they had been investigated thoroughly and if there was insufficient information, the electronic form was sent back to the individual senior person to complete in more detail.
- Patients were transferred out of the hospital by emergency ambulance if they developed conditions or complications whilst they were receiving treatment for

their cancer, for example bleeding or cardiac problems. This happened on average twice per week. However, these were not recorded as incidents on the hospital reporting system.
- Mortality and morbidity (M&M) meetings were held quarterly. All deaths in the service were recorded. The Divisional Chair for Cancer reported all MVCC inpatient deaths at the M&M Clinical Governance. Any cases which could have resulted in learning were reported by the consultant in charge of that particular patient's care.
- Alerts received externally requiring action, for example alerts from the National Reporting and Learning System (NRLS) were circulated to all the trust leaders, with a date for feedback or actions. These were effectively followed up. This meant appropriate action was taken with regards to any national alerts.

Duty of Candour

- Staff understood their responsibilities with regards to patients being told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result. We saw evidence of this with regards to a serious incident.

Safety thermometer

- The hospital gathered patient information such as hospital acquired infections and reviewed these through its clinical governance processes. We did not see this displayed in the hospital. However the hospital website for patients provided clear information about overall incidence of MRSA, C. Difficile and MSSA. In addition we saw safety data which was routinely collected by the trust. This showed that out of 40 patients included in the audit, one had come to harm, which is equivalent to 2.5% of patients audited. However, as the chemotherapy service is deemed to be an outpatient service, these were not directly related to that service. Patients were risk assessed for venous thromboembolism (VTE). The VTE screening rate had been consistently 100% compliant.

Cleanliness, infection control and hygiene

- There was an up to date infection prevention and control policy available on the intranet. Staff were able to access it and were aware of its contents.
- Personal protective equipment (PPE) was worn during administration and disposal of cytotoxic medication and when dealing with a cytotoxic spillage. Equipment included gloves, gown/apron, eye protection and mask.
- There was a policy for cytotoxic spillage and staff were aware of what to do and where spillage kits were stored. In addition there was an awareness of the process to follow should a member of staff become contaminated with cytotoxic material.
- Chemotherapy waste was disposed of in purple topped sharps boxes and designated bags, as appropriate, in line with national guidance. All the sharps bins that we saw in the chemotherapy units were locked and not overfull.
- Clinical waste was stored in locked compounds outside the building. In addition, all the waste bins we saw were locked.
- Handwashing audits were carried out every two weeks and we saw there was good compliance, the previous month had shown 95% compliance. There was an action plan in place to effect improvements.
- There had been no reported incidents of MRSA or C Difficle in the two years prior to our inspection.
- We saw the results of cleanliness audits for all the cancer centre, which included the chemotherapy suites, showed almost 100% compliance.

Environment and equipment

- All areas appeared clean. However, the building was old and required updating and refurbishment. There was generally a lack of space. Staff told us some parts of the building were cold in the winter. We saw windows that would not close properly. Although many of the hospital's facilities were housed in one main building, there were a number of essential services which were in different buildings, meaning patients had to go outside to access them.
- There was a dual system for reporting faults, some departments used a paper based system, others the trust's electronic system. It was not clear what the rationale was for this. Staff reported that generally there was a poor response to maintenance requests.
- Resuscitation equipment was checked daily and documented as complete and ready for use.
- There was sufficient equipment, for example intravenous pumps and subcutaneous drivers, to maintain safe and effective care.

Chemotherapy

- The patient-led assessment of the environment (PLACE) survey score for the hospital was 98% for cleanliness, 95% for food and 98% for privacy and dignity in 2015. We saw a specific action plan following the PLACE audit to ensure improvements were made.

Medicines

- There were arrangements in place for managing medicines, including chemotherapy and radioactive substances to keep people safe. This included obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal.
- Chemotherapy was prepared by another provider, which was situated within the Mount Vernon site. The hospital received regular reports of the effectiveness of their quality assurance systems. This meant they could be assured that the chemotherapy provided had been prepared aseptically (in a bacteria free environment.)
- There was a pharmacist who had a specialist qualification in oncology. We checked a range of medicines on both the chemotherapy suites and found that they were stored safely. This included Controlled Drugs and chemotherapy. If medicines were not given, there was a reason for this annotated on the patient's electronic drug chart.
- Nurses undertook an annual medicines and chemotherapy administration competency. This was repeated and extra support was given if a medication error was made.
- Chemotherapy was manufactured, aseptically, by an external provider. Chemotherapy was suppled on a named patient basis and was prescribed electronically via a specific chemotherapy electronic system.
- If patients were given chemotherapy tablets as a take home medicine, they were given specific advice on how they should be stored and handled.

Records

- Patient's records, except for their chemotherapy treatment, were paper based. Chemotherapy was prescribed, ordered and administration recorded using an electronic system. The records we saw were accurate, complete, legible, up to date and stored securely.
- The chemotherapy service operated a paper-lite system (i.e. as many records as possible held electronically) and was moving towards a paperless system (i.e. all records held electronically).
- All electronic records were password protected. Staff used electronic signatures within the system to sign-off their actions and to reduce delay.

Safeguarding

- There were systems in place to make safeguarding referrals if staff had concerns about a vulnerable adult. The staff we spoke with talked confidently about the types of concerns they would look for and what action they would take.

Mandatory training

- Most staff were trained in essential safety systems, processes and practices.
- There was an electronic rostering system in place. This tracked staff members days off, leave and training. Heads of departments could see from this system how their department and individuals were complying with mandatory training. Mandatory training rates for all staff were at the hospital target of 90%. We saw from reports that it had been a challenge to reach this level of mandatory training.
- Many of the nurses, band 5, 6 and above were trained to administer chemotherapy. All were required to complete a mandatory annual update in order to continue to undertake this extended role.
- The hospital relied on a large number of volunteers; there were about 300, who worked at the hospital. They carried out a number of tasks, including manning reception desks and providing complementary therapies for patients. All completed a comprehensive application form and underwent a five week induction which included three days training in communication, cancer and customer care.

Assessing and responding to patient risk

- The hospital had an acute oncology service (AOS) in line with the recommendations of the National Chemotherapy Advisory Group report (2009). This enabled a rapid response to be given when patients developed symptoms, for example, neutropenic sepsis, uncontrolled nausea and vomiting, uncontrolled diarrhoea or complications associated with venous access devices. The team included a named consultant oncologist who was the clinical lead, a band 8a nurse based at the Lister Hospital and a band 6 nurse at MVCC. The team used the United Kingdom Oncology Nursing Society (UKONS) triage and decision kit.

Chemotherapy

- All patients receiving chemotherapy were advised of the risk of neutropenic sepsis whilst they were undergoing chemotherapy. Neutropenic sepsis is a life threatening condition whereby the chemotherapy adversely affects the body's ability to resist infection by affecting the bone marrow and decreasing white blood cell production. Patients were given an alert card, which described key symptoms of sepsis and a number to call. The calls went through to a dedicated phone that was manned 24 hours per day. There were 12 nurses who were trained to answer these calls. They provided a service to The Lister Hospital and two other neighbouring trusts, so that patients had a rapid response if they were concerned. If it was established that the patient may be unwell, they were advised to come to the hospital, or if they lived a distance away, to their nearest emergency department.
- There was a procedure in place to minimise chemotherapy being given via the incorrect route. There was a policy in place dated February 2014 with regards to the administration of intrathecal (into the cerebrospinal fluid) chemotherapy. It referenced Health Circular August 2008 and Patient Safety Alert February 2014. There was an ordering, prescribing and administration register in the pharmacy. There were six consultants that were trained and deemed competent to prescribe and administer intrathecal chemotherapy. Intrathecal chemotherapy was given to patients in a side room only and not delivered to where it was to be administered until all intravenous therapy had been completed. Each dose was signed by the doctor, a pharmacist and a nurse.
- The hospital did not have the facilities to manage patients whose condition was deteriorating, or who developed conditions or complications whilst they were receiving treatment for their cancer. All the senior nurses had undergone a competency framework to assess and monitor patients who were deteriorating. There was as senior nurse who assessed and could give first line treatment. In addition there was support from an on call anaesthetist. Therefore, they were referred to other centres for ongoing treatment. Patients who were deteriorating were transferred to The Lister or another neighbouring trust for urgent treatment.
- The hospital sent a senior nursing representative to the trust's patient safety committee where serious incidents, complaints, alerts and sharing best practice.

Nursing staffing

- Staffing levels, skill mix and caseloads were planned and reviewed so that people received safe care and treatment at all times.
- There was a local induction process in place for bank and agency nurses, the induction consisted of a checklist used to ensure temporary staff were familiar with the environment they were working in.
- The hospital appeared to be adequately staffed. We saw that from data that the trust provided us with that the vacancy rate for all registered nursing staff, June 2015, was 10 (4%). For care assistants the rate was 3. (<0.5%)
- Staff reported to us that the permanent staff mostly covered vacant shifts by working extra. The ward staff reported that they had high agency usage, however, the data provided by the trust demonstrated that in June 2015, there were 534 whole time equivalent (WTE) staff of which 146 were nurses and 29 were care assistants. During this period, there were nine WTE agency staff (2.6%) and 12 WTE bank staff.
- Staff told us and we saw from the rota that any agency staff that were used worked regularly at the hospital.
- The hospital had 10% vacancies, an 11% turnover and a 4.3% sickness rate of which 2.3% was short term.

Medical staffing

- Doctors of all grades at MVCC were almost fully recruited to. None of the doctors told us they felt that the service was understaffed. Therefore, the use of locum staff was rare.
- We noted that these oncologists provided outpatient clinics at a large number of hospitals in distant locations across the area. This meant that many of the medical staff were not always in the main cancer centre. The clinical director ensured that all staff were in the department one afternoon per week (the same afternoon for all) so that they could participate in audit and information sharing.
- Junior doctors told us they felt well supported by the consultants, both whilst they were on site and if they needed to be called out of hours. They described the training they received as, "very good." There were regular consultant led ward rounds, teaching rounds, teaching meetings and MDT, which junior doctors attended.

Major incident awareness and training

Chemotherapy

- There was a trust wide major incident plan in place, dated 2015. Staff were aware of the escalation process if there was an incident requiring a major response.

Are chemotherapy services effective?

Good

We rated chemotherapy services good because:

Patients had their needs assessed, their care goals identified and their care planned and delivered in line with evidence-based, guidance, standards and best practice.

Pain was assessed and managed, although audits were not available. Patient's nutrition and hydration needs were assessed and met.

The hospital took part in local, trust and national audit programmes. Audits were undertaken of patients records each month were audited against compliance with assessment tools and care bundles. The hospital was meeting the 31 day target for treating patients who required chemotherapy and radiotherapy for most tumour types.

Staff had the right qualifications, skills, knowledge and experience to do their job, however completion of mandatory training was below the trust's target. Staff were encouraged to take on new responsibilities.

All the consultants specialised in treating one or two tumour sites only. We found that there was a strong culture of multidisciplinary working between nurses, specialist nurses, doctors, allied health professionals and social workers. This included both inter hospital multi-disciplinary working and from hospital into the community.

Staff were aware of their responsibilities surrounding consent. The hospital consent forms complied with Department of Health guidance. None of the staff we spoke with had received training about the Mental Capacity Act 2005 (MCA).

Evidence-based care and treatment

- Patients had their needs assessed, their care goals identified and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- As part of their treatment, patients were offered complementary therapies which were all evidenced based and shown to improve the patients' well-being.
- Patients were assessed to ascertain whether they were suitable for PICC line insertion, for example if their treatment involved certain regimes or they were needle phobic.
- Approximately twenty seven PICC lines were inserted by two specialist nurses, per month. This service was only available for three days per week. There was an interventional radiologist available for advice, should it be needed. The hospital audited insertion rates and complication rates, every six months. The insertion success rate was 97.5%. Audits showed that since the reduction in the number of nurses carrying out insertion, complication rates had decreased. The infection rate was 2.5% (0.2 per 1000 patient days) which is very low.
- Thrombosis rates were 4.3%, whereas nationally they were 6.67%.
- A key indicator of successful access to treatment is access to intravenous antibiotics within one hour for patients who were suspected of having neutropenic sepsis. We saw that the last audit that was made available to us from The East of England Cancer Network in April 2015, relating to 47 patients, showed that audit results for the whole network showed only 30% of patients received antibiotics in two hours. However, the data from MVCC analysed separately, showed that 82% of patients received antibiotics within one hour and 91% within two hours. This was an improvement on 2014, when less than 20% of patients across the network, received their treatment within an hour. The audit showed that in 25% of admissions, it was unclear when the first dose was given. However, these patients were not always admitted to MVCC and could have been to the patient's local trust. Education was ongoing with regards to the role of the acute oncology service in order to highlight these patients required antibiotics rapidly.
- Trust wide, septicaemia mortality data from Dr Foster for the rolling year ending June 2015 was 82 (HSMR) and 88 (SHMI). However, these patents had not all been treated at MVCC.

Chemotherapy

- There was a sepsis improvement plan in place dated May 2015. We saw minutes form the trust's sepsis group meeting, who met bi-monthly and planned to improve antibiotics received within an hour to 95%.

Pain relief

- Pain was assessed and managed. We saw that patients were prescribed medicines for pain relief, which were given as prescribed and needed. The reasons for non-administration were recorded.
- There was guidance for prescribing palliative medication and guidance for use of anticipatory medication at end of life, which provided guidance for pain relief.
- Staff told us syringe pumps used to give a continuous dose of painkillers and other medicines were available to help with symptom control in a timely manner.
- We requested audits of pain control. However, these were not available.

Nutrition and hydration

- We saw that the patient's nutrition and hydration needs were assessed and met. Patient's nutritional needs were assessed using the Malnutrition Universal Scoring Tool (MUST).
- Patients were weighed at every new interaction during their treatment to assess weight gain or loss. Patients were referred to a dietician if they had lost weight and required advice or dietary supplements, for example calorie loaded drinks. We spoke with a patient who had been admitted with nausea following chemotherapy. They had a comprehensive care plan with regards to nutrition and hydration and had been reviewed by the dietician almost daily.
- Snacks were available in both chemotherapy units and in the wards and patients had drinks within reach.
- A quality assurance inspection which was carried out during July 2015 on ward 11 found staff were adhering to the protected meal time process, that the nutritional and hydration needs of their patients were being met, documentation to support this practice was in place, the food was hot and that the patients were satisfied with the quality of the food served.

Patient outcomes

- Patients had their needs assessed, their care goals identified and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- The hospital took part in local, trust and national audit programmes. A variety of local audits took place, for example documentation and IV fluid management. National audits included, for example, neutropenic sepsis, and outcomes from oesophageal and lung cancer. In addition MVCC undertook specialist audits, within the cancer network and nationally, for example, spinal cord compression and advanced breast cancer treatment. Results compared favourably against national benchmarks. We saw other local audits, for example treatment with certain types of chemotherapy. These had been undertaken in an effort to improve compliance with documentation and to formally measure patient's pain control.
- There was a recognised pathway for dealing with patients who were suspected of having a spinal cord compression due to their cancer, whereby they would be admitted to their local hospital for assessment and an MRI scan. Following this there would be a discussion between the clinical team at a designated hospital with neurosurgical facilities to decide a treatment plan. This could be surgery, radiotherapy, symptom control and palliative care, depending on the patient's needs at the time.
- Twenty sets of patients records each month were audited against compliance with assessment tools and care bundles, for example, NEWS, urinary catheter insertion and peripheral line insertion. Results were discussed at team meetings. In addition, NEWS audits were carried out by the external provider of resuscitation training. All the audits we saw were showing favourable results, for example the peripheral line audit showed 97% compliance against the care bundle.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job. There was a trust and individual induction. All the staff we spoke with told us that the induction was useful and met their needs.
- We saw that at September 2015, 90% of staff were up to date with mandatory training which was the trust target. This training included fire, infection prevention and control and basic life support.

Chemotherapy

- Almost all (90%) of appraisals had been completed. Appraisals were linked to salary increments. Staff told us they found the appraisal system useful to discuss their progress and career aspirations with their line manager.
- There were education notice boards in staff areas.
- Staff told us there was a variety of means through which they received vital communication. They described staff meetings and notice boards. We saw minutes of meetings, which at senior level were held regularly and were comprehensive. However, at more junior level and staff we spoke with felt they did not always receive essential information.
- The trust circulated a monthly team brief, this was trust wide and not specifically for MVCC. We reviewed several briefs and found very little pertaining to MVCC. However there was a MVCC specific newsletter produced by the local management team which was circulated to all staff by email on a monthly basis. We saw a version dated September 2015.
- Staff were encouraged to take on new responsibilities. The hospital had a post graduate centre where most of the training took place. One member of staff told us, "There's always some sort of training going on". However, some non-professional staff told us they felt that much of the training went on at The Lister Hospital site, which was harder for them to access.
- There was a senior nurse in place who undertook all the training staff required with regards to intravenous (IV) access, for example phlebotomy and insertion of peripheral lines.
- All the consultants specialised in treating one or two tumour sites only. This meant that they had expert knowledge of the care of the patients they were treating.
- The Acute Oncology Service (AOS) ran a rolling programme of training and education within the trust's emergency departments and medical admissions unit where unwell patients may be admitted, to heighten awareness of the needs of patients undergoing treatment for cancer.
- There was a range of competencies in place with regards to use of equipment, for example, intravenous and subcutaneous pumps/syringe drivers. Most of these competencies were assessed by staff who had undergone 'train the trainer' education.
- Most patients received their chemotherapy on a day case basis; therefore chemotherapy was administered less frequently on the inpatient wards. In order that the inpatient nurses maintained their skills, the nurses rotated into the chemotherapy units.

Multidisciplinary working

- We found that there was a strong culture of multidisciplinary working between nurses, specialist nurses, doctors, allied health professionals and social workers. This included both inter hospital multi-disciplinary working and from hospital into the community.
- There was a daily multidisciplinary bed meeting to ensure all admissions were admitted to the right place. For example, someone who was to be admitted for chemotherapy if they were frail or unwell would have been allocated to one of the beds, rather than a chair in the in the chemotherapy suite, so they were more comfortable.
- In addition there were daily ward rounds where discussions were held with regards to patients with advanced disease and their management, symptom control, psychological care and discharge.
- An MDT meeting was held regularly at The Lister Hospital to consider patients who had presented with metastatic cancer of unknown primary (CUP). This is in line with NICE guideline CG104 (February 2014).
- There were separate MDT meetings according to tumour types.
- Junior doctors reported that there was a good relationship between the oncology and palliative care service and said they often asked for advice around controlling patients symptoms.
- There were a number of specialist nurses who worked closely with all members of the multidisciplinary team supporting patients and their families. However, it was reported that more were required to provide care for patients with some types of tumours.

Seven-day services

- Patients were reviewed daily on the wards and every time they presented for treatment if undergoing day case chemotherapy.
- The consultants took part in an on call rota. Junior doctors reported that they were easily contactable and responsive.

- Consultants worked on a rotation and were responsible for ensuring the unit had adequate clinical cover from junior doctors at all times when a consultant was not on duty on the unit.
- Most facilities were available out of hours, this included physiotherapists, radiographers and radiologists, all available at night and weekends.
- Junior doctors reported that although it was easy to obtain scans, which were available on site, it was often more difficult to arrange interventional radiology. An example were liver biopsies under ultrasound control, due to availability of radiologists at the nearby acute trust where they were carried out.

Access to information

- Staff were able to show us how to obtain key policies, for example infection prevention and control and chemotherapy guidelines on the hospital's intranet.
- Results of blood tests and x-rays were readily available.
- Discharge letters were sent to the patient's GP with details of the treatment provided, on the day of discharge detailing follow up arrangements and medicines provided. These were often, but not always copied to the patient for their information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had an up to date consent policy that staff were familiar with.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people.
- We looked at twelve sets of notes and saw consent forms were fully completed, signed and dated by the consultant, or specialist nurse and patient. The forms identified the planned chemotherapy treatment, the associated risks and benefits and intent of treatment. In addition, there were associated toxicity profiles. We saw separate consent for when the patient was taking part in a clinical trial in conjunction with the hospital's research centre. These were signed by the consultant and patient, not the specialist nurses. The hospital consent forms complied with Department of Health guidance.
- None of the staff we spoke with had received training about the Mental Capacity Act (MCA) to ensure they were competent to meet patients' needs and protect their rights where required. This also included training regarding The Deprivation of Liberty Safeguards (DoLS). They explained they would contact their clinical lead for advice and involve the consultant and relatives as appropriate.

Are chemotherapy services caring?

Outstanding ☆

We have rated this service as outstanding for caring because:

Staff clearly understood the impact of the patient's care, treatment or condition had on their wellbeing and on those close to them and often went out of their way to ensure patient care went beyond their remit as healthcare professionals.

Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition.

Patients and relatives were well supported, in a variety of ways and were given as much or as little information as they wanted.

Compassionate care

- Staff understood the impact the patient's care, treatment or condition had on their wellbeing and on those close to them.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition.
- Staff took the time to interact with people who used the hospital's services and those close to them in a respectful and considerate manner.
- We saw and heard of some excellent examples of compassionate care. Every patient we spoke with was extremely complimentary about the care they received. One told us, "I know this building is old, but what goes on in here is marvellous. Everyone is so nice. I can't fault it." Another said, "It's wonderful here. I can't thank them enough. Everyone is kind and really understands. They've all become part of my family."
- Exceptional arrangements were made to enrich patients' social and personal lives. We heard moving stories of how staff had, "Gone the extra mile," to gain

charity funding, given up their own time and, via personal contacts, been able to ensure that patients and their families could have life enhancing experiences.
- Staff were offered communication training, which include listening skills so that they were able to understand and be considerate to patients' needs. This training was extended to include volunteer staff.
- According to the Friends and Family test, 99% of patients would recommend the hospital to their friends and relatives. There was a response rate of 69%.

Understanding and involvement of patients and those close to them

- The hospital, via The Lynda Jackson Macmillan Centre, held information sharing groups for patients, prior to them receiving chemotherapy and radiotherapy.
- Patients and relatives told us they were well supported and were given as much or as little information as they wanted.
- Relatives were actively encouraged to become involved in their loved one's treatment plans.
- All the patients we spoke with were aware of what to do if they felt unwell.
- Some, although not all reported that they were given a copy of the letters sent to their GP outlining their progress with treatment.

Emotional support

- It was clear that staff took the time to interact with people who used the hospital and its services. We saw that staff were always respectful and considerate and humorous, when appropriate, towards patients and their relatives and those close to them.
- The Lynda Jackson Macmillan centre provided support to patients who attended the hospital and their families. Within the centre there was information about treatment and side effects, support groups and a range complementary therapies and other therapies, for example relaxation classes for all and acupuncture for some women with early breast cancer. In addition counselling was offered as well as advice on financial assistance. The centre was supported by all the professional staff groups and volunteers who had been specifically trained.
- Chemotherapy specialist nurses would visit patients at home prior to their chemotherapy commencing, if the patient was particularly nervous.

Are chemotherapy services responsive?

Requires improvement

We have rated responsiveness as requires improvement because:

Services were not always organised so that they meet people's needs.

Essential pre-treatment blood tests and treatment could be carried out on the same day, however, whether patients chose this option, or had their tests done on one day and treatment on the next, there were always long waits. There were almost always long queues in the outpatients department for patients to be registered, although patients who were nervous, for example, if they were needle phobic, were seen and reassured as soon as possible.

There was almost always adequate parking for patients; however in order that patients did not have to pay large charges, they were required to purchase a token, which for many involved a very long walk from some of the car parks.

The service to insert peripheral inserted central catheters (PICC) lines, operated three days per week. This meant patients sometimes had their first treatment without the PICC line in situ. When patients required specialised treatment by a plastic surgeon following extravasation, they needed to be transferred off site.

Staff had not had any training to care for patients with dementia. There were links to access special care for patients with a learning disability.

Where it was found a patient may breach a waiting initiative, they were prioritised for urgent treatment.

The hospital had an on-site hostel for patients who were having daily treatment, but did not need an in-patient bed.

The ratio of compliments far exceeded the complaints. However, we found that not all complaints, particularly verbal complaints were recorded.

Service planning and delivery to meet the needs of local people

Chemotherapy

- An electronic referral and booking system was in place which linked local hospitals directly to MVCC. Although this was a recent improvement, it was introduced in an effort to reduce booking delays.
- Many of the patients had their chemotherapy delivered via semi-permanent intravenous lines, for example Hickman or peripheral inserted central catheters (PICC) lines. Two nurses had received training to insert the PCC lines. Arrangements could be made for patients to have them 'flushed' by the community nurses or their local hospital, to minimise inconvenience for patients having to travel long distances back to Mount Vernon. The patients were offered a choice of returning to MVCC or having their line flushed locally.
- The external provider of chemotherapy was open Monday to Friday. Chemotherapy was manufactured and delivered to the hospital, on a named patient basis, according to a service level agreement. In addition, there was access to the site on Saturdays in case chemotherapy was required urgently.
- Extravasation is a recognised complication of chemotherapy, whereby toxic medicines escape into the tissues rather than being confined to the vein. This can cause anything from a minor skin reaction to severe tissue injuries. The more serious reactions require rapid assessment by a plastic surgeon, which is best practice. Patients who had a mild reaction were treated locally according to the hospital' extravasation policy. However, if further treatment was required, the patients needed to be transferred to The Lister Hospital.

Access and flow

- Patients had timely access to initial assessment, diagnosis or urgent treatment. Where it was found a patient may breach a waiting initiative, they were prioritised for urgent treatment.
- Patients were scheduled using an electronic system which maximised the use of the chemotherapy chairs in both the Mount Vernon and The Lister Hospital sites.
- The hospital was meeting the 31 day target for treating patients who required chemotherapy and radiotherapy. However, within urology, the wait was longer, up to 62 days. This reflected the national trend. In an effort to improve these waits, bottlenecks in timing pathways were being reviewed. These waiting times were reported to the trust board as a whole, however, they could be broken down by tumour site if required.
- Patients, who lived some distance from the hospital, could have assessments carried out prior to their treatment, via telephone. This was done by one of the specialist nurses.
- Essential pre-treatment blood tests and treatment could be carried out on the same day. Patients who lived some distance from the hospital preferred this. However, it meant that they were waiting in the hospital for blood tests results and then for their chemotherapy to be prescribed and made up. Often, if the chemotherapy suite was busy, this meant a long wait in the busy outpatients department. One patient told us, "I always have to wait two to three hours before my treatment starts. It makes it a very long and tiring day."
- Patients who lived nearby could have their blood test done on one day and their treatment the next, in an effort minimise waits. However, patients and staff reported some considerable intervals of time for all patients whilst chemotherapy was prescribed and signed off on the electronic system and then for it to be made up and administered. One told us, "If the treatment was signed off quickly on the system by the doctors, everything would be much quicker."
- An audit of waits for chemotherapy treatment was carried out in September 2015, which showed that:
  - 49% of patients were seen and treated within 30 minutes
  - 12% waited 30-60 minutes
  - 39% waited more than 60 minutes
- Senior nursing staff told us they realised that some of the waits patients endured were unacceptable. Much work had been done to introduce the 'one stop' treatment system and reduce waits and this was ongoing. Several staff told us that a lot of work had gone on to reduce the waiting times.
- There were two nurses who inserted PICC lines; the service was only available three days a week. Senior staff reported to us that sometimes there was not enough space for patients to have their PICC lines inserted before their first treatment. Several senior staff told us it would ease pressure if the PICC lines could be inserted five days per week.
- We saw long queues in the outpatients department and down a main corridor for patients to be checked in for treatment. This happened at all times of the day. Staff told us there should always be two receptionists to ensure that patients were dealt with quickly, telephones answered promptly and patients' notes obtained.

However, there was only ever one, with a reliance on volunteers to fill gaps. Patients told us there were always long waits to register. One said, "I'm really grateful for the treatment I get here, but I don't think it's very good when I have to wait in a long queue when I don't feel very well." Another told us, it was not unusual to arrive for an 11am appointment and not be seen until later in the afternoon. The patients we spoke with told us that generally they were not kept up to date with why there were delays.

- The hospital had a shared care arrangement with two London hospitals who specialised in the treatment of young people aged 16-24. This meant young people could have their critical treatment in a unit that met their particular needs and more routine treatment at MVCC, nearer their home.
- There was sufficient parking near all the main facilities for patients. This included spaces for patients who had a mobility disability. Parking was administered by an external contractor engaged by Hillingdon NHS Trust. Parking for patients was free for the first 30 minutes. Following this there was a charge. For example up to two hours it cost £3.00 and up to seven hours it cost £10.50. If patients had an appointment or were receiving treatment, they could purchase a token at the man hospital entrance, which cost £1 and lasted for the day. However, in order to purchase a token, some patients had a very long walk from some of the car parks. Several staff and patients told us that it would be easier for the patients undergoing chemotherapy if there was a place in the chemotherapy suite to purchase tokens. We observed several patients who were unable to purchase tokens as the reception had run out of them. This was compounded by the cashier's office, where further tokens were kept, being closed for a lunchbreak. Although the receptionist was doing their best to assist the patients, it was clear the patients were distressed about potentially being late for their treatment and the risk that their car would be clamped.

Meeting people's individual needs

- Patients who were nervous, for example, if they were needle phobic, were seen and reassured as soon as possible.
- Cold caps were offered to patients undergoing chemotherapy, where there was a risk of hair loss. Staff were able to give us individual examples of where changes, some small, had been made to make things better for patients. For example, the bathroom area in the chemotherapy suite did not have a mirror. One of the patients told a member of staff that it was difficult to see if they had put their wig on straight, as they has lost their hair, following treatment. Therefore a mirror was placed into the bathrooms.
- The hospital had links with the specialist Learning Disability (LD) team at The Lister Hospital, who provided support when needed. There were LD link staff in each department. However, the link team was a recent initiative and two link staff told us that they had not had the opportunity to attend learning sessions or meetings about their role.
- The staff told us that they made adjustments and provided extra support for patients with a learning disability, for example, any waiting was minimised and the same nurse cared for the person, in order that a relationship could be built up. This extended to nursing staff working outside their own department in an effort to provide support and continuity. However, staff we spoke with were unsure about any provision or the availability of easy read advice leaflets.
- None of the staff we spoke with had received training to support people with dementia. However, said they would ensure any patient who had particular needs would be given extra assistance.
- There was an Access to Interpretation services flowchart. This was used to ascertain the assistance a patient may need if they had a communication difficulty. This included both language and sensory difficulties. The flow chart gave contacts so that staff could access the correct assistance.
- Telephone translation services were available.
- Patients we spoke with were unanimous in their praise with regards to the care and attention they received. They told us their call bells were answered promptly and their needs were anticipated and met.
- Free Wi-Fi was available for patients.
- The hospital provided educational podcasts for patients.
- The hospital had an on-site hostel for patients who were having daily treatment, but did not need an in-patient bed. The patient could have a companion or carer with them, had to supply all their own food and beverages and be self-sufficient. One patient said, "I stayed there when I had to be here every day and it was too far and stressful to drive home every time. I was so grateful."

Chemotherapy

- There was a multi-faith chapel and a separate prayer room, both used for religious services, or quiet prayer and contemplation. Information both verbally and in writing, was available for a range of conditions, treatments and associated needs, for example with regards to hair loss.

Learning from complaints and concerns

- Complaints from patients were rare. There were 33 recorded complaints in 2014-2015, of which 47% were responded to within the agreed timeframe. The ratio of compliments far exceeded the complaints. However, we found that not all complaints, particularly verbal complaints were recorded. Some of the departments had their own system of recording complaints, which were shared ineffectively locally and not recorded or shared centrally. This meant that the hospital did not have an accurate oversight on complaints and concerns raised by patients or their loved ones. There was varying degrees of knowledge with regards to learning from complaints and concerns. The more senior staff were aware of learning, but generally more junior staff told us they had not had such information shared with them.

Are chemotherapy services well-led?

Requires improvement

We rated chemotherapy services as requiring improvement with regards to being well led.

The trust had a single vision to 'be among the best'. This was underpinned by three trust wide strategy elements, one of which was to focus on the development of the Mount Vernon Cancer Centre site. The other two strategy elements were; 'keeping promises on value and quality' and 'new services and ways of working through partnerships.'

Although each division within the hospital had local objectives and there were objectives for the cancer centre as a whole, there was no principal cancer strategy, nor was there a director with sole responsibility for cancer. There was no strategic oversight of the chemotherapy service. The trust had produced several strategy documents, although MVCC did not feature prominently.

There was no oversight of the number and reason of for transfers out of the hospital for urgent treatment.

The leaders of the service understood the challenges to good quality care and could identify the actions needed to address them. All staff were aware of the trust's vision. There was a plan in place to be autonomous from Hillingdon NHS Trust.

All the medical staff had an afternoon of management time written into their contracts.

People who had used services, and those associated with them were actively engaged and involved in the hospital.

All the staff we spoke with were proud to work for the Cancer Centre and would want their friends and family to be treated there should the need arise.

Vision and strategy for this service

- Each division within the hospital had local objectives. Staff we spoke with, both clinical and managerial, during the inspection were not aware that there was a defined cancer strategy in place that detailed the actions to be taken in developing the service, or the part they and their team played in the development and improvement of the service.
- A brief outline of the cancer centre's objectives was provided for us to see after the inspection, dated June 2014, was not referred to during the inspection and did not contain what would be expected in a strategy document. For example, it outlined objectives, which were incomplete, there was no team or person referred to who had responsibility for achieving individual objectives and there were no measures in place to ascertain how and whether the objective had been achieved.
- There was no director with sole responsibility for cancer. There was no strategic oversight of the chemotherapy service.
- The hospital shared the trust's vision: We put our **P**atients first. We strive for excellence and continuous **I**mprovement. We **V**alue everybody. We are **O**pen and honest. We work as a **T**eam. All the staff we spoke with were aware of the vision and its acronym, PIVOT. We saw posters around the hospital. The trust told us that overall, 10% of their staff had been involved in developing this vision. However, none of the staff we spoke with had knowledge of who had developed the vision. Staff did tell us though that PIVOT was incorporated into both the appraisal and recruitment process

Chemotherapy

- There was a plan in place to be autonomous from Hillingdon NHS trust with regards to land and building ownership by the end of March 2016. This would allow MVCC to develop the hospital so that's its facilities could be brought up to date. However, at the time of our inspection, this plan had yet to be finalised. Plans to modernise the wards, outpatients, nuclear medicine, replace the linear accelerators, (radiotherapy machines) expand the Lynda Jackson Centre and link the hospice to the hospital could then be realised, if planning was granted and funding was available.
- Clinical activity was increasing at approximately 5% per year. Senior management told us they monitored this regularly it the QIT meetings. This informed their longer-term plans for service development.

Governance, risk management and quality measurement

- The hospital had a risk register but it was not clear how often it was reviewed. Risks specifically relevant to chemotherapy were discussed at the chemotherapy QIT.
- All the medical staff had an afternoon of management time written into their contracts. Once a week the hospital held a governance meeting. It was mandatory for the medical staff to attend regularly. The senior staff reported that since this had been mandatory the medical staff were more engaged with governance issues. The subject matter and presenter varied each week. Audits, incident reviews and plans and disease topics were discussed. Whilst we were there one of the consultants presented and led a discussion on cancer of the ovary.

Leadership of service

- The leaders of the service understood the challenges to good quality care and could identify the actions needed to address them.
- All the senior staff we met were enthusiastic and motivated and wished to ensure that the patients received the very best care.
- It was clear that the senior staff, many of whom had been working at the hospital for some time, were supportive of each other. All the staff we spoke with spoke highly of the senior nursing team.
- The trust clinical director met regularly with the clinical director at MVCC.
- It was reported to us that the trust executive team and the board were not seen as frequent visitors to the hospital.

Culture within the service

- Although staff felt actively engaged within the hospital, many staff commented that they felt, "Like a satellite service." Or; "Second class citizens to The Lister." Some staff told us that much of the training, including induction took place at The Lister, which meant long journeys for some staff, so they were disinclined to attend.
- Staff described how generally they felt respected and that their contribution was valued by the team. However, some staff sought us out and told us individually that not everyone was treated fairly. It was clear this was down to local management.
- There was a strong culture of teamwork and commitment from most staff to ensure the patients were treated well. We observed good team working, and there was a pleasant atmosphere. One member of staff said, "Everyone just pitches in and helps." Staff felt supported and allowed to use their own initiative within reason and described that MVCC had a positive learning environment**.**
- The staff sickness absence rate for the trust was lower than the England average at around 4%. A staff member explained they had required a long-term absence from work but felt they had been well supported on their return to work and were complimentary of their colleagues and manager in the support they had received.

Public engagement

- People who had used services, and those associated with them were actively engaged and involved in the hospital.
- The hospital had a good reputation within the local community and beyond.
- The hospital had a large team of volunteers who supported the hospital in most departments. They manned various receptions providing a meet and greet service, preparing refreshments, working in all departments as assistants, running activities and fundraising. The volunteers were seen as part of the team. One member of staff told us, "Our volunteers are wonderful. I don't know what we'd do without them."

- The hospital's website was user friendly and helpful. There was information about different types of cancer and their treatments. In addition there were signposts to other organisations who may have been able to offer assistance and advice.

Staff engagement

- All the staff we spoke with were proud to work for the Cancer Centre and would want their friends and family to be treated there should the need arise. Staff told us they liked making sure the patients received continuity and the best care possible. All the staff we spoke with said they had time to spend with patients, when they needed it.
- We saw that while the staff at MVCC had a strong affiliation to the Mount Vernon Cancer Centre brand; the affiliation to the East and North Herts NHS Trust was less strong.
- There had been a consultation and reorganisation of some staff, which had caused some resentment within those departments. However, this had not affected most staff.
- Staff surveys had shown that many staff cited stress in the workplace as a negative consequence of working at MVCC. The leaders of the service were aware of this and the stress that often accompanied caring for people who have a life threatening or life limiting condition. Therefore as a result of a staff survey concerning this, staff were offered complementary therapies by the trust.

Innovation, improvement and sustainability

- The hospital was a member of the East of England Local Cancer Network. Data from the Acute Oncology Service (AOS) was shared with other hospitals in the region.
- The hospital had a research and clinical trials department. Nationally MVCC were in the top 100 trusts for research. The Government's Plan for Growth, published in March 2011, announced the transformation of incentives at a local level for clinical research to measure the performance and both initiating and delivering research projects. At the time of our inspection MVCC had submitted data for both initiating and delivering eight research projects, which were still in progress.
- Although the Mount Vernon Cancer Centre was situated on The Hillingdon NHS Trust's Hospital site, it was run by North and East Herts NHS Trust. The Cancer Centre used some of Hillingdon hospital's facilities, for example their diagnostic MRI and CT scanners and their operating theatre for long IV line insertion. There had been some complications with the site as the building and site were owned by Hillingdon NHS Trust and there had been some reticence to maintain and invest in the site and the building. However, there had been some beneficial negotiations in the months prior to our inspection and the leaders of the Cancer Centre were confident that the site and buildings would be handed over to their control in early 2016. This meant that essential improvements could be made to the centre.
- Several senior staff told us of developments with regards to telemedicine and telehealth and ongoing work to link up with two other acute trusts in order that the data could be shared across Hertfordshire and beyond.
- Many of the patients received ongoing care within the community setting, for example blood tests or line flushing. It was common practice for the community teams to work shadowing the specialist nurses so that they could learn how to care for patients who were having treatment in a specialist centre.
- Nurses we spoke with were aware of the Nursing and Midwifery Council's (NMC) revalidation scheme. The hospital had held a number of workshops to support the nursing staff through this.
- The hospital had developed a booklet for patients with head and neck cancer, which had recently won a national award.
- We saw a variety of trust strategy documents, including people strategy 2014-2019; sustainability strategy 2015-2020; and patient and carer experience strategy 2015-2019. However, there was very little in all these documents pertaining to MVCC particular needs and requirements. This was reflected in a sample of board papers that we reviewed.

Radiotherapy

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

Information about the service

From April 2014 to March 2015, there were 4,185 episodes of radiotherapy delivered at Mount Vernon Cancer Centre, and that there were 56,579 attendances for radiotherapy.

The service provides radiotherapy and supporting treatment to the population of 1,937,737 people across East and North Hertfordshire.

There are seven linear accelerators (radiotherapy machines) available for clinical use, plus brachytherapy, stereotactic radiotherapy. There is a radiotherapy physics service that supports the treatment delivery. A nuclear medicine service is available on site.

There is a management team for the cancer centre which includes a clinical director, senior manager and lead nurse.

Summary of findings

There was a good culture of safety. Incidents were reported, investigated and lessons learnt.

The radiotherapy service had a good range of clinical equipment to meet the latest standards of care.

The radiotherapy service provides IMRT (Intensity Modulated Radiotherapy) and IGRT (Image Guided Radiotherapy) to a high standard.

The radiotherapy service was a major contributor to national clinical trials.

Staff were well trained. There was an effective system for ensuring and measuring competencies. There was a strong multidisciplinary team work ethos. There was an integrated electronic records system ensuring staff could access clinical information in all places where it was required.

We saw staff were very caring. We observed a supportive volunteer system adding strength to the clinical teams positive approach. The Friends and Family Test results for cancer services were 98.9%. Patients, and where appropriate, their relatives, were involved in their care.

Some parts of the hospital were not in a good state of upkeep, such as the nuclear medicine unit. The unit was cold in the winter and let draughts through the windows.

The service performed well against the 31 day waiting time standard for subsequent radiotherapy.

Radiotherapy

There was a strong leadership team in the Mount Vernon Cancer Centre. The Radiotherapy Management team were recognised by everyone we spoke to as being highly effective. This was highly valued by members of the clinical team.

The leadership team could articulate their plans for the future, but did not have this as a written strategy agreed by the trust. We were not able to see a cancer plan for the Mount Vernon Cancer Centre.

There were strong governance systems in place. Review of information and audit supported management actions. Key risks concerning equipment had been recognised and added to the hospital's risk register. Regular Quality Improvement Team meetings were held. We saw evidence of their impact.

There was clear evidence of both staff and patient engagement in service provision and development.

The service was highly innovative and demonstrated many areas of good practice.

Are radiotherapy services safe?

Good

There was a good incident reporting, review and learning culture. The service regularly reviewed morbidity and mortality data. Infection prevention control was well managed, staff followed good practice and the service was visibly clean.

The radiotherapy service had sufficient equipment of a good standard with access to a service continuity machine to avoid breaks in treatment. Some areas of the service were more remote from the main treatment floor. Medicines were prescribed by medical staff, with limited arrangements in place for Therapeutic Radiographers to prescribe or dispense medicines to patients.

The service was moving towards a paper-lite system; reducing the risk of transcription error and interpretation. This process had begun. We saw this move was well managed, but carried a risk of duplicate systems until complete.

There were sufficient staff to undertake the duties required.

Incidents

- There had been no never events in the radiotherapy service in the past 12 months (August 2014 to August 2015). Never Events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- During the 12 month period, cancer services reported 581 incidents. Of these, 93.1% were low or no harm incidents. 1% were moderate harm. 5.3% of these were not graded. Only two incidents were graded at the highest level.
- This indicated a good reporting culture, where staff reported incidents that had not led to harm to allow learning from these incidents to prevent further harm.
- All incidents were reported on the trust wide incident reporting system.
- The service held monthly management meetings where incidents were discussed. Trends in incidents were also examined. Action plans were discussed and agreed. Following the meetings, emails were sent to the teams to share lessons and actions with them.

- Immediate learning issues were shared at the service staff meetings for all professional disciplines.
- Every three months the service held an information sharing and awareness meeting for all staff. This meeting was held in working hours to allow all staff to attend. The meeting was used to ensure all staff understood the lessons from previous incidents and encouraged learning to be embedded.
- Of the reported incidents, 21% related to radiotherapy directly, and was the largest proportion of all categorised incidents.
- Incidents relating to the dose of radiation received were reviewed by the Medical Physics Expert (MPE). An analysis of the error/incident was undertaken. The MPE and the patient's consultant were both required to have reviewed and signed off the response to the incident.
- The radiotherapy service reported incidents as required following the Ionising Radiation (Medical Exposures) Regulations 2000. These reports were made to the IR(ME)R team at the CQC. The service had two reports currently open, that is, not yet fully investigated and staff were able to describe the process used.
- We saw that two serious incidents had occurred during this period, August 2014 - August 2015. One related to the nuclear medicine service. The incident related to a member of staff, not a patient. We saw that the service responded appropriately to the incident. We reviewed the serious incident report prepared following the incident and saw that all reasonable steps had been taken.
- The service held quarterly morbidity and mortality (M&M) review meetings. All deaths in the service were recorded. The Divisional Chair for Cancer reported all in patient MVCC deaths at the M&M Clinical Governance meeting. From these the Divisional Cancer Director chose which cases were discussed at the M&M meeting; this avoided selection bias Any cases which could have resulted in learning were reported by the consultant in charge of the case.
- The meeting was an open meeting and could be attended by all staff (including junior doctors and non-medical staff).
- The trust reported safety thermometer data at cancer service and ward level. There was no data displayed for the radiotherapy service.
- Staff we spoke to understood the words: 'Open and honest' as more recognisable terminology than Duty of Candour.
- We saw good examples of where staff in the radiotherapy service had understood and followed duty of candour.

Cleanliness, infection control and hygiene

- There had been no cases of MRSA and C.Difficile reported in the service in the two years before our visit.
- Audit data for the six months from January to June 2015 showed 100% compliance with an environmental hygiene audit.
- We saw that during our visit, all areas were visibly clean and tidy.
- We observed the use of 'I am clean' stickers allowing staff to be confident the equipment they were using had been cleaned.
- From the trust's patient experience questionnaire, we saw that of 227 patients surveyed between 1 April and 30 October 2015, all reported that the service was either very clean (91.2%) or fairly clean (8.8%). 85% of patients described the toilet facilities as clean.
- Hand hygiene audits undertaken by the service showed compliance with infection prevention and control (IPC) as consistently in excess of 90%.
- We saw that staff were bare below the elbows in line with the trust's policy.
- Staff who were unable to comply with the bare below the elbows policy for religious or cultural beliefs wore disposable sleeves to ensure that IPC was maintained.
- Staff used hand gel between episodes of care and were encouraged to wash their hands after using gel five times. We saw that staff followed this practice.
- We saw that there were hand gel opportunities at the point of patient contact in radiotherapy; for example at the entrance to each treatment unit; however hand gel dispensers were less visible in corridors and patient areas. This did not encourage patients to use hand gel before entering the department.

Environment and equipment

- The department was well maintained.
- There was a clear maintenance plan for the radiotherapy equipment.
- We saw a programme for equipment replacement and renewal of leases. We did see that this plan was approximately 12 months behind schedule.
- We saw that while some equipment had been extended beyond its original replacement date, there was a clear and structured plan.

Radiotherapy

- We saw that the department had a wide range of equipment available for use and this included some of the latest radiotherapy equipment available.
- There was recognition of the risks associated with equipment failure. This was annotated, the impact assessed and control measures in place on the hospital's risk register.
- There were seven Linear Accelerators available for routine use. In addition to this there was one service continuity Linear Accelerator. This is recognised as good national practice so that patient's treatment is uninterrupted during machine service or breakdown. Research has shown breaks in treatment lead to poorer outcomes. There was also one stereotactic radiotherapy unit.
- The nuclear medicine service were looking to purchase a single-photon emission computed tomography (SPECT) scanner. This is a type of scanner using radioactive material to produce a 3D image of the way organs work in the body. This aids both diagnosis and treatment planning.
- The nuclear medicine service was based in accommodation that was inappropriate for their use. The building was old and staff told us that the windows that let draughts in.
- The radiotherapy physics planning area was well laid out with sufficient space for staff to work effectively.
- The department operated a paper-lite system where most data was held on the computer system. This reduced clutter and kept the work environment clear. It also minimised the risk of mixing papers and instructions.
- The linear accelerators were mainly located in groups of two with a sub-wait area and a door to the main corridor. This gave waiting patients a large degree of privacy and also maintained the corridors free from crowding and trip hazards.
- Some parts of the service were very spread out (e.g. Linac 1 and brachytherapy) with some machines being quite remote and isolated from other parts of the department. This could have caused problems if staff needed to call for help.
- Therapeutic Radiographers 'ran up' the treatment units each day; a process which involves bringing them up to operational readiness and undertaking quality assurance checks. Therapeutic Radiographers received training from the physics service to undertake this task.

Medicines

- Medicines were prescribed by medical staff, with limited arrangements in place for Therapeutic Radiographers to prescribe or dispense medicines to patients.
- There were no patient group directives (PGD) in place within the service.
- One permanent review radiographer had a supplementary prescribing qualification.

Records

- We looked at the process for checking resuscitation trolleys. We found that all equipment had been checked, was in date and this was regularly recorded.
- The radiotherapy service operated a paper-lite system (i.e. as many records as possible held electronically) and was moving towards a paperless system (i.e. all records held electronically). They planned to manage this process in a staged way, migrating one cancer site at a time. The service had already moved its treatment of prostate cancer to a paperless system. Other cancer sites were due to follow in a managed process. This had the potential to increase risk with duplicate systems being operated by the service.
- Records of patient's treatment were held within the system.
- Information on all aspects of a patient's radiotherapy were available to all staff.
- We saw sufficient terminals and access points to allow staff to be able to retrieve information as required.
- Staff working on the linear accelerators, (radiotherapy treatment), radiotherapy planning and in radiotherapy physics had access to the same records system.
- The system also covered nuclear medicine and chemotherapy.
- Documents held in the quality management system were also available for staff to access. This included procedures, protocols and work instructions.
- Records were password protected.
- Staff used electronic signatures within the system to sign-off their actions and to reduce delay.
- The service used the CASPER system to book patient's appointments and manage patient flow.
- We reviewed 10 patient records. We saw a variable quality; for example, where these were paper based we saw poor quality photocopies of some records included in the notes. We saw the 'information given to the

patient' section was not always well completed. This meant subsequent members of the clinical teams were not aware of what information the patient had been given.
- The nuclear medicine service was included on the trust wide imaging system (Radiology Information System). This allowed information from nuclear medicine scans to be shared with clinicians and accessed where required.

Safeguarding

- Safeguarding training was fully up to date. Records showed that 100% of staff had completed adult safeguarding training. This included safeguarding training for children level 1 and level 2.
- Staff we spoke with understood their responsibilities for safeguarding and knew what to do if there was a concern.
- Refresher training was managed through the records kept by HR and staff were advised by HR when they required updates. We saw that this process worked well.

Mandatory training

- Mandatory training was monitored and managed through the HR department. The system was efficiently and effectively managed.
- Alerts were raised when a member of staff was due for a training update. Staff received a personal email reminder from HR when training was due. Staff engaged with this system well.
- Mandatory training covered, for example, fire training and manual handling.
- We reviewed the records kept by the HR department and this showed that overall there was 98.4% compliance with mandatory training.
- Records showed that compliance with equality and diversity, infection control and moving and handling training were 100%. Information governance and fire training were 91%.

Assessing and responding to patient risk

- During our inspection, a visitor to the department was taken ill and collapsed. This needed an emergency medical response by the clinical team of the department and the hospital. We saw that the response to this serious incident was highly professional. Staff in the service were calm and proficient. We saw that this was a good response to an emergency situation; staff knew the procedure to follow.
- The radiotherapy service operated a radiotherapy quality system which was accredited to the ISO 9001:2008 quality standard (similar to the British standard kite mark). This ensured that all procedures that the department undertook were all documented. All procedures had a work instruction that detailed the task required.
- We noted that the accreditation plaque (for the ISO quality system) had expired in June 2015. We were aware that the system had valid accreditation, but the plaque was out of date.
- All new staff to the service were required to read the quality system to understand the tasks and how they were undertaken at Mount Vernon Cancer Centre.
- The quality system was audited regularly and this was checked as part of the accreditation process.
- There were over 100 documents in the system. We saw that there were a small number (seven) that had just passed their review date within the past four to six weeks. We saw that the service were actively reviewing these and reissuing updated versions.
- The radiotherapy service saw patients regularly during their treatment. This meant that patients who might deteriorate or have reactions to their treatment could be managed in a timely way.
- Patients were reviewed daily by the radiographer treating them as part of the treatment process. This allowed the treatment team to assess changes in patient's condition on a daily basis.
- We observed that staff followed good procedures to identify that the correct patients were being treated. The treatment software allowed the patient's photograph to be uploaded onto the system. This gave an additional check on top of the mandatory patient verbal identification check (name, address and date of birth) that were always undertaken. We noted that the staff always followed this process.
- The department operated a paper-lite system where most data was held on the computer system. This reduced clutter and kept the work environment clear. It also minimised the risk of mixing papers and instructions.

- The service operated an out of hours on-call system for patients who required urgent radiotherapy. There was a clear on-call arrangement and procedure for cover.
- The on-call rota was held on the shared drive on the trust's IT system so all staff had access to it.
- The radiation protection committee met regularly. We saw minutes of the meeting that showed appropriate discussion of the relevant items including incidents, working practices and quality assurance.
- Not all staff were fully conversant with the operational policies of the services. In most observations staff knew what to do, and which policies to follow; however we observed one example where there was a lot of discussion about whether a patient could be transferred to another machine because they needed a different appointment time the next day. Staff were unaware of the transfer policy. We later confirmed this policy with the deputy head of the service.
- Some consultants were still prescribing radical treatments on paper based treatment sheets, whilst others were doing this electronically. There was an inconsistent approach to this. Staff managed this well, but it had the potential for misunderstanding.

Therapeutic Radiographer staffing

- Therapeutic radiographers staffing was consistent with the recommendations set out by the Society and College of Radiographers.
- Staff told us that they felt the staffing levels were sufficient to allow them to do their jobs.
- We noted some use of radiographic agency staffing at the trust; but we saw these were on longer term arrangements and so staff were familiar with the service and its procedures.
- We observed one Linear Accelerator (Linac 1) being run by two agency radiographers. Both had worked at the trust since July 2015. There was a newly qualified member of staff in an observing role plus a student radiographer. There was no permanent member of staff as part of this clinical team.
- The agency staff demonstrated a good level of clinical competency and understanding; however they were less familiar with the department or its procedures.
- Sickness rates amongst radiographic staff were below 4%. This was consistent with the trust's average.
- In Radiotherapy OP clinics a number of clinics were held when there were not the appropriate number of nursing staff. From 23 April to 31 July 2015 334 clinics were held. Of these we saw that 214 (64%) had run understaffed.
- Agency staff were booked as longer term arrangements. They began as supernumerary/supervised until the senior radiographer on the treatment unit gave positive assessment to the superintendent radiographer. Agency staff had induction/competency assessments before being given the rights to be able to use the patient information system.
- Vacancies were well managed. During our inspection, we saw that five new staff were planned to commence work, starting at the end of November. Five staff were on maternity leave and these posts had been back-filled.

Radiotherapy Physics and Nuclear Medicine Staffing

- Staffing levels for radiotherapy physics were within the guidelines of the Institute for Physics and Engineering in Medicine (IPEM) recommendations.
- We saw that although headcount appeared sufficient, the service could not always be assured that the skills mix was appropriate. With the high level of complex work undertaken in the radiotherapy physics service access to experienced staff was potentially a challenge. Overall the service managed this challenge well.
- In nuclear medicine staffing levels were satisfactory. However, the service was geographically isolated from the rest of the physics service. This had the potential to exacerbate staffing challenges.
- Physics staff told us they felt there was generally enough staff in the team to undertake the work required.
- Staff told us there were a number of staff on term time contracts, but this did not impact on the delivery of the service.

Medical staffing

- There were sufficient oncologists to provide specialisation in all the major cancer sites.
- There were 18 clinical oncologists who prescribed radiotherapy; they were supported by 13 junior medical staff in training.
- There was an oncologist lead in each tumour speciality. Medical staff worked well together.
- We noted that these oncologists provided outpatient clinics at a large number of hospitals in distant locations across the area. This meant that many of the medical staff were not always in the main cancer centre. The

clinical director ensured that all staff were in the department one afternoon per week (the same afternoon for all) so that they could participate in audit and information sharing.

Major incident awareness and training

- There was a trust major incident plan which detailed guidelines should there be an interruption in service. However, we did not ask staff about this during our inspection.

Are radiotherapy services effective?

Good

The radiotherapy service provides IMRT (Intensity Modulated Radiotherapy) to a higher percentage of patients than the England average. The service provided a good range in IGRT (Image Guided Radiotherapy). Together these were indicators of a high quality radiotherapy service. The department followed national policies in treatment planning and treatment delivery.

The radiotherapy service was accredited to the ISO 9001 quality standard. This consisted of clear policies, protocols and work instructions. This was externally accredited and regularly audited for compliance.

The radiotherapy service was a major contributor to clinical trials. We heard that staff were significantly concerned about their ability to maintain this position with an increasing level of demand and activity.

Staff were well trained. There was an effective system for ensuring and measuring competencies. This was available and staff could identify who was able to undertake each task. Funding for training was available.

There was a strong multidisciplinary team work ethos. Staff worked well in their teams and across professional boundaries. There was a healthy respect for each other's ability and role.

There was an integrated electronic system ensuring staff could access clinical information in all places where it was required.

Staff understood safeguarding requirements and their responsibilities under the Mental Capacity Act.

Evidence-based care and treatment

- Intensity Modulated Radiotherapy (IMRT) is recommended by the NHS commissioning clinical reference group as the gold standard of care. IMRT allows the intensity of the radiotherapy plan to tailored to the size, shape and other dimensions of the tumour. This reduces the amount of normal healthy tissue included in the treatment area. This has two benefits, firstly a reduction in the side effects from treatment. Secondly it allows the potential for a higher dose of radiotherapy to be given if this is deemed beneficial.
- The National Cancer Action Team identified that at least 24% of patients should be offered radiotherapy using IMRT. The trust agreed with commissioners that this would be a monitored target called a CQUIN (Commissioning for Quality and Innovation) which encourages care providers to share and continually improve how care is delivered.
- The National Clinical Analysis & Specialised Applications Team (NATCANSAT) monitor levels of IMRT in England on behalf of NHS England. Data from NATCANSAT for the six months prior to our inspection (March – August 2015) showed that against a national standard of 24% IMRT rates, Mount Vernon Cancer Centre was achieving an average of 44.4% IMRT (range 41%-51%). This compares very well with an England average of 40.3% for the same period.
- The data showed that of the 51 radiotherapy centres in August 2015, Mount Vernon Cancer Centre was the eighth highest provider of IMRT in England.
- Data from NATCANSAT also showed that IMRT was delivered to many cancer types by the radiotherapy service. This meant a wide range of patients were able to benefit from this technique.
- The radiotherapy team used fiducial markers to aid the accurate planning and treatment delivery of the treatment plan. The markers are implantable devices designed to act as reliable surrogates for imaging anatomic structures of interest. This is recognised as good practice by the relevant professional bodies such as the Royal College of Radiologists.
- We observed that the service was undertaking treatment imaging on all new breast radiotherapy treatments. Best practice would have encouraged this to be done before treatment starts for this patient group, rather than the current process. We were not able to identify an imaging protocol for staff to use in this case.

- Treatment planning followed recognised good practice. The clinical oncologist and the treatment planner both sat together to work on the task. This allowed good communication between the two professional groups and ensured that the intention of the oncologist was understood by the staff members developing the radiotherapy plan.

Pain relief

- During our inspection, we did not see patients in distress or requiring pain relief.
- Patients requiring a clinical review for their pain were seen by the medical staff. We saw that the radiographic staff knew the procedure to access a medical review.

Equipment

- The centre had three dedicated Radiotherapy planning CT scanners installed, two were in routine use. There was one permanent staff member in each scanner and additional staff were on rotation to improve learning.
- Mount Vernon Cancer Centre had a range of equipment available, many of which provided the latest in high quality radiotherapy.
- Equipment to provide Image Guided Radiotherapy (improving the accuracy of the treatment beam), Intensity Modulated Radiotherapy (improving the way the radiation dose conforms to the tumour volume) and Stereotactic Radiotherapy (for small tumours requiring short high dose treatment) were all in routine use. These techniques have all been identified in various national bodies as leading work in improving outcomes and survival.
- Treatment planning software was of the highest specification and the radiotherapy team were constantly reviewing and expanding its use. For example during our visit, the team were discussing the next roll-out of software with added functionality. This would have further improved the quality of radiotherapy delivery.
- The brachytherapy suite was very well equipped with a 0.3 Tesla open access MRI in situ; which is more than sufficient for requirements of the case mix. (Tesla is the measurement of the strength of the magnet in an MRI scanner).

Nutrition and hydration

- During our inspection we observed that staff undertook intentional rounding in the main waiting areas. This is a process where staff actively checked patients are comfortable and have access to something to drink, need the toilet and access to food if they have been waiting a long time.
- There was a structured approach through a written form and escalation plan to intentional rounding.
- There was access to drink and food in the main waiting area.

Patient outcomes

- Clinical protocols were widely available to staff on a shared drive. Staff confirmed that consultants adhered to the protocols.
- There was a nominated individual responsible for ensuring these were kept up to date.
- The Mount Vernon Cancer Centre had a strong reputation nationally for contribution to national clinical trials. The centre had good recruitment to trials and contributed to improved outcomes through developing new treatment protocols.
- Senior staff in the service expressed concern that their potential for contributing to this in the future was being eroded. They were concerned that the medical and other clinical workforce required for clinical trial and research was being increasingly directed to daily service delivery. This limited the amount of time spent both on research activity and on sharing good clinical practice across the wider radiotherapy community. Those staff we spoke with felt this would have a negative impact on the overall patient care outcomes.
- Developments were initiated due to service need or to improve clinical treatments. One example of improvement to treatment outcome was Deep Inspiration Breath Hold technique. This was introduced by the service to reduce the amount of cardiac tissue in the radiation field. This reduces radiation damage to the heart for patients having breast or chest wall radiotherapy (particularly the left breast).
- Patients received weekly cone beam scans as part of their treatment. This is a part of Image Guided Radiotherapy (IGRT). This allowed a 3D reconstruction of the treatment volume to match to the planned target volume. Therefore therapeutic radiographers were able to identify if the treatment volume was still correct. Cone beam scans for head and neck cancer patients were reviewed in planning as well as on the treatment unit to proactively identify in advance need for re-scan.

- Independent checks on the dose calculation were undertaken with a commercial system. This verified that the calculated dose matched that planned and delivered and significantly reduced the risk of operator error.
- The radiotherapy service were taking part in radiotherapy clinical trials to improve outcomes. One example was brachytherapy for focally boosted prostate monotherapy using a template treating indexed lesion to 21Gy whilst the rest of gland was treated to 19Gy 1#. A Gray (Gy) is a unit of radiation dose. Clinicians were then using dose escalation.
- Patients were followed up locally initially following their treatment in line with national best practice.
- The service were undertaking a number of local audit projects including:
  - Audit of prostate and nodes treatment with fiducial markers.
  - Audit of low residue diet in patients having abdominal radiotherapy.
  - Audit of a patient positional accuracy on a support device (wing board) with or without additional support. We did not see the results of these audits during the inspection.

Competent staff

- We saw that there was a good system for assessing and approving staff competencies.
- We looked at records of staff training which was held in the department. There was a comprehensive local record of individual staffs' development.
- A bi-annual report was sent to the radiotherapy manager from the HR department, to check registration of clinical staff with the Health and Care Professions Council (HCPC).
- In treatment planning we saw a visible record of staff training with dated competencies.
- In radiotherapy physics, we saw that the competencies of specialist registrars to sign off consultants plans, was clearly documented. Each consultant had assessed, through observation, the ability of junior medical staff to agree a treatment plan. The list of who was permitted to sign off plans was held in a shared file to which all staff had access.
- When we asked members of the physics planning team to show us this list, they were easily able to locate and open the file. This showed that they were used to finding and using the competency list.
- The medical exposures committee met regularly. As part of its agenda it reviewed staff competencies for the Ionising Radiation (Medical Exposure) Regulations. A matrix of staff competencies was in place in radiotherapy, radiotherapy physics, nuclear medicine and radiation protection.
- Staff described continuous professional development (CPD) opportunities to allow them to enhance their training and skills. There was some funding in local budgets for training, with access to central CPD funding.
- A forecast for CPD funding was made at the start of the year. Access to funding created through running national study days added to the funding available.
- Staff belonged to a journal club to allow team members to reflect on recent publications and improved their knowledge of subject areas through collective discussion and learning.
- Four therapeutic radiographers had been trained to undertake breast radiotherapy treatment mark-up. This is a task historically undertaken by medical staff.
- Two therapeutic radiographers had been trained to undertake clinical radiotherapy mark-up for patients with metastatic spinal cord compression. This was a task historically undertaken by medical staff. The service was ready to extend this to include all metastatic spinal treatments.
- A trainee physicist on a radiotherapy training scheme had previously been recognised as the best MSc student on the national training programme and won best overall student. This reflected well on the quality of clinical training in the service.
- For patients requiring radiotherapy for prostate cancer using IMRT; the consultant would contour (outline) the treatment volume and agree the dose constraints. The physicists would plan the treatment and if there were no issues and everything was within protocol, meeting prescription and dose constraints, a competent physicist could sign off the plan. This avoided delay to the patient's treatment.
- Radiation protection training was delivered regularly to ward staff by the physics service. Updates and bite size training were being developed. The team relied on ward link nurses to ensure training and cascade to other staff happened. Nurses from the ward spent time in brachytherapy to support their learning.
- Volunteers all had a formal interview and three days training. This included communication, cancer awareness and customer care.

Radiotherapy

Multidisciplinary working

- We observed strong team working at all levels of the service.
- Staff took part on the training of other disciplines (for example on image training). This ensured that the training had recognition of the impact on other disciplines.
- Staff were comfortable in working across their professional groups.
- We saw that staff were respectful of each other and their role in the team.
- We observed in the brachytherapy suite a calm professional interaction between radiotherapy physics and therapeutic radiographers.
- Each oncologist was prepared to sign off another's treatment plan (within the level of their own expertise and competence). This avoided delays for the patient. It demonstrated a strong team working relationship between medical staff.
- There were good arrangements between the Mount Vernon Cancer Centre team and other hospitals in the East and North Herts NHS Trust. We saw there was agreement to transfer patients requiring additional care to other sites in the trust.
- There were arrangements in place for patients who required transfer to specialist cancer centres, who required additional expertise not available in the trust (for example for rare cancers or those with specialist clinical requirements).
- There was a good relationship with other clinical services, for example pharmacy.
- Strong multidisciplinary team working was evident at management level. We saw that plans for purchase and location of new equipment engaged all disciplines. New techniques, new procedures and changes to systems were considered by the Quality Improvement Team (QIT); this involved all team leads coming together monthly to consider the impact of new ways of working and consider implementation plans.
- There was a main QIT to oversee the programme and smaller QITs to take on individual work programmes. This ensured that many members of the multidisciplinary tea were able to contribute.

Seven-day services

- The radiotherapy service operated from 8am to 8pm.
- There was an on-call system during the weekend for urgent access to radiotherapy.
- There was a bank holiday on-call service, staffed by three therapeutic radiographers between 9am and 12 noon.
- There was a named consultant rota for out of hours contact. This rota also included junior medical staff support.
- We saw that annual leave rotas for consultant staff were available to all to allow continuity planning.

Access to information

- The radiotherapy service had an integrated (paper-lite) IT system.
- Staff could access all the relevant documents from their PC. All staff had access to a PC.
- Information was held on the trust's 'knowledge centre' which acted as a central area for storing information that staff would need.
- Documents specifically for radiotherapy services (for example on-call rotas and staff competencies) were held on a shared drive so all staff could access them.
- Staff in all areas had access to the radiotherapy management system. This managed work flow, patients' appointments and other key clinical information. We saw that there were sufficient terminals in appropriate places to ensure that all staff had access.

Consent and Mental Capacity Act

- Patients consent to treatment was obtained at the clinical consultation phase. Patients confirmed their consent at scanning and prior to treatment.
- Staff understood the Mental Capacity Act and were able to describe the appropriate steps. A system was in place within the service to support mental capacity assessments.
- A mental capacity advocate in the trust (based at the Lister Hospital) could be contacted and would support a patient if there was any conflict or concern.

Are radiotherapy services caring?

Good

We saw staff were very caring. We observed a supportive volunteer system adding strength to the clinical teams positive approach.

Radiotherapy

The Friends and Family Test results for cancer services was 98.9%

Patients, and where appropriate, their relatives, were involved in their care.

Patients had access to supportive services at the Lynda Jackson Information Centre.

Compassionate care

- We saw that staff approached patients in a caring way.
- We observed one patient at the reception desk being spoken to in a very supportive way by the reception staff. They told us that the patient's first experience is often with them, and that they see it as setting the standard of personal care.
- Patient feedback about the service was positive. Patients reported that the staff were very caring. Within Cancer Services, the Friends and Family Test (the proportion of patients willing to recommend the service as good to friends and family) was 98.9%. There were no detailed results specifically for radiotherapy.
- During radiotherapy, the radiographers were not able to remain in the treatment room. We saw that the staff on the radiotherapy treatment units used an in-room microphone to communicate with patients. This allowed patients to communicate with staff without feeling isolated.
- Patients we spoke to were highly complementary about the quality of care they received.
- Patients were encouraged to fill in comment cards and put these on a dedicated notice board. All the cards we read were very positive.
- We spoke with three patients, all in separate waiting areas within the service. All three patients were highly complementary about the care they had received.
- The linear accelerators were mainly located in groups of two with a sub-wait area and a door to the main corridor. This meant that patients waiting had a large degree of privacy.

Understanding and involvement of patients and those close to them

- We spoke to the relatives of patients who were receiving radiotherapy. They described how they also felt involved (with their relatives consent) in their care. They described the clinical staff as being very supportive.
- One relative describe how a patient they accompanied was deaf. They described how staff modified their approach to the patient to ensure that the patient had a full understanding of their treatment process.
- We saw there was a self-check-in system at the radiotherapy reception. One person was unsure. The member of reception staff took time to engage the person in how to use the system. They helped them learn the process for next time by involving them in understanding what was required. We saw that the patient was more confident afterwards.
- We spoke with volunteers who staffed the information desk by the entrance to radiotherapy. Patients who required information to help them understand their care could access it from this volunteer office. We saw it was easily accessible; although we noted it was located in a draughty corridor. We spoke to the team on duty who told us that the clinician would identify the appropriate information, but if patients or relatives made a general enquiry they would give them generic information.
- We observed that this information point was well used. The volunteers were highly enthusiastic about the benefit of their role to support patients understanding of their radiotherapy and care.

Emotional support

- The Lynda Jackson Macmillan cancer information centre was available to patients on site.
- There had been 36,000 requests for information and support in the last year.
- Support was provided to patients through counselling and supporting therapies.
- The centre provided a range of evidence based alternative therapies to help manage side-effects of treatment for example ear acupuncture.
- The radiotherapy service had specialist radiographers with designated roles as experts in certain treatments and cancer types, to support patients through their clinical care.
- A team of volunteers were available in the service to support the patients during their wait.

Radiotherapy

Are radiotherapy services responsive?

Good

Some parts of the hospital were not in a good state of upkeep, such as the nuclear medicine unit. The unit was cold in the winter and let draughts through the windows.

The service performed well against the 31 day waiting time standard for subsequent radiotherapy.

There was a good system for responding to machine breakdowns to avoid patient delay.

The service used patient complaints and comments to learn and we saw evidence changes following patient feedback.

Service planning and delivery to meet the needs of local people

- Data from the National Clinical Analysis & Specialised Applications Team (NATCANSAT) showed that for the financial year Aril 2014 to March 2015, there were 4,185 episodes of radiotherapy delivered at Mount Vernon Cancer Centre, and that there were 56,579 attendances for radiotherapy. This equates to an average of 13.5 attendances per episode. Over the same period, the England average was 14.2 attendances for radiotherapy. This meant patients receiving radiotherapy at Mount Vernon Cancer Centre required less visits to the cancer centre for radiotherapy.
- We saw, and we heard from staff, that some parts of the fabric of the hospital required significant maintenance. We heard that this was causing substantial operational challenges. We spoke with the senior management team and to clinical staff who described these challenges. For example, the radiotherapy service was planning a SPECT scanner (Single-photon emission computed tomography) which is a nuclear medicine tomographic imaging technique using gamma rays. However, the building in which the Nuclear Medicine team worked was not appropriate for installation of the scanner without significant remedial work at a high cost. Staff told us how the old building let in draughts and was unpleasant in the winter.

Meeting people's individual needs

- We saw that the team were able to be flexible in changing appointments to meet individual people's needs. This also reflected the long travelling distances some patients had to make.
- There was access to the Lynda Jackson Macmillan cancer information centre. This provided support to patients attending for radiotherapy and other cancer treatment.
- Where patient's first language was not English and they were unable to understand what was said to them, the trust had a register of staff who spoke different languages that could be called on to interpret. This is not considered good practice as it risks compromising patients' privacy.
- Members of staff in the Lynda Jackson Centre were trained to use sign language for patients who were deaf or had very limited hearing.
- An audit of the pre-treatment process showed variability in patient satisfaction of the privacy and dignity at the pre-treatment appointment. There were no changing rooms, and no space to install any additional rooms. The team responded by putting up curtains in the CT room to create personal space for patients.
- The audit also identified variability in patient perception of the value of information given during the pre-treatment appointment due to the lack of personal space. Following this, a full explanation was now given in private before starting and the patient was left alone to undress.
- Staff on the radiotherapy treatment units telephoned the radiotherapy clinic staff to advise them that the patient was ready to be seen. This avoided patients being delayed in the system.
- There was a self-check-in system at radiotherapy reception. This allowed patients to avoid long queues at reception and to book-in their arrival through a computer interface.
- The service had a Learning Disability Champion.
- The Lynda Jackson cancer information centre website provided information for patients to access before their treatment. This allowed patients to become involved in understanding their treatment process before they attended the service. It is designed to minimise the anxiety caused by an unknown process.

Radiotherapy

- Funding had been secured to develop a podcast for patients undergoing head and neck chemo-radiotherapy. These will eventually be available on the Lynda Jackson Cancer Information centre website for patients to download.
- We noted (but did not visit) that a cancer information centre is also available on the Lister Hospital site.

Access and flow

- NHS England monitored the proportion of patients receiving radiotherapy for their subsequent treatment within 31 days of agreeing to receive radiotherapy. For September to December 2014 96.8% of patients met this standard, against an England average of 97.9% (Range 87.2% - 100%). Between January and March 2015 this figure was 96% against a 97.8% England average and between April – June 2015 it was 94% compared to an England average of 97.6%
- The service had planned an audit of patients' flow through the department. Results of this were not available during our visit.
- The service was open to patients from 8am to 8pm.
- The Quality Improvement Team (QIT) monitored access data and examined pathways for patients where they fell outside of the standard.
- The QIT took action to make improvements. For example, the clinical process to begin radiotherapy for head and neck cancers had recently changed and improved the time taken for a specific section of the patient journey reduced from three weeks to two weeks.
- We observed that on one day of our visit, one of the treatment machines had broken down. We saw that the system for rescheduling patients worked well, and that patients' delays from an unavoidable event were kept to a minimum. There was a clear policy in place to support staff in making decisions on rescheduling and transfer of patients to specific alternative treatment units.
- Senior staff regularly monitored any delays in appointment times. If a treatment machine was running one hour behind, staff would intervene and reallocate patients to avoid lengthy delays.
- If there was a consistent problem senior staff would investigate the underlying cause.
- There were dedicated administrative staff for scheduling and booking appointments. This ensured focus on getting patients to treatment quickly. They booked all parts of the pathway (including patients having radiotherapy and chemotherapy at the same time). Staff were based with the MDT coordinators and the secretaries so there was good exchange of information.
- Consultants were regularly in the booking office, and staff felt they had good access to the consultants if they were unsure of anything.
- Where the appointment was scheduled to take place within the next five days or less, the member of staff would telephone the patient to ensure they had received the message and got the maximum notice possible.
- There was active tracking of patients' cancellations and the reasons were recorded.
- Staff worked on specific pathways so they were familiar with the requirements and the questions patients may ask.
- Therapeutic Radiographers did not use PGDs for access to medications. This meant that patients who required medication had to wait to see two members of staff to get their prescription. Once in radiotherapy, then again in outpatients to see a doctor.
- Car parking was a concern for a number of patients we spoke with. Access to parking spaces concerned patients in arriving on time for their appointment. Access to parking payment was confusing for some patients. It had a negative impact on patient experience.
- We noted that the management of car parking was undertaken by a third party provider but we saw evidence of the impact on patients' experiences of care at Mount Vernon Cancer Centre.

Learning from complaints and concerns

- Patients were encouraged to comment on the care they had received.
- There was a leaflet available to patients (called Comments, Compliments, Concerns, Complaints) which included all feedback options for patients within one leaflet.
- We saw that the service encouraged patients' comments and complaints.
- We also saw that the trust encouraged local resolution of concerns by staff before the escalated into a formal complaint.
- Cancer Services had seen a reduction in formal complaints from 47 in 2013/14 to 33 in 2014/15. Data were not available for radiotherapy specifically.

Radiotherapy

- We did note that the proportion of complaints responded to in the agreed time had fallen (worsened) from 74% in 2013/14 to 47% in 2014/15.
- Each of the clinical divisions for the trust had a patient experience action plan addressing opportunities to resolve issues and improve overall patient experience. This action plan was monitored by the patient experience committee of the trust which was chaired by a non-executive director.
- Recent examples of action across Mount Vernon Cancer Centre included reviewing the discharge process and care pathways.
- A notice board by the radiotherapy reception desk encouraged patients to fill in comments on their care. These comments were available for staff to read.
- Where patients did not want their comments to be seen by others there was a sealed box that patients could post comments to.
- There was a, "You said – we did" board in the waiting room where staff were able to identify to patients and visitors where they had changed services as a result of patients feedback. For example, an area for patients waiting on a trolley was created following comments from patients about waiting in corridors.
- Patients complained about waiting times for Consultant led clinics. In response to this, the service had changed the environment by improving the waiting areas and reviewed the clinic template. A re-audit of this then showed improved patient feedback following the changes.
- A patient complaint about not knowing which staff would be on duty led to a display board being put up with names and photos of the staff on duty in each area.
- Staff on the radiotherapy reception told us that they were informed if patient's comments were negative and any improvements made to the service.
- The service encouraged local resolution of complaints.

Are radiotherapy services well-led?

Good

There was a strong leadership team in the Radiotherapy service. The management team were recognised by everyone we spoke to as being highly effective. This was highly valued by members of the clinical team. The executive team were less visible in non-clinical areas. There was a positive culture; staff felt engaged in (and part of) the Mount Vernon Cancer Centre.

The leadership team could articulate their plans for the future, but did not have this as a written strategy agreed by the trust. We were not able to see a cancer plan for the Mount Vernon Cancer Centre.

There were strong governance systems in place. Review of information and audit supported management actions. Regular Quality Improvement Team meetings were held. We saw evidence of their impact.

There was clear evidence of both staff and patient engagement in service provision and development.

The service was highly innovative and demonstrated many areas of good practice.

Vision and strategy for this service

- The trust had a single vision to 'be among the best'. This was underpinned by three trust wide strategy elements, one of which was to focus on the development of the Mount Vernon Cancer Centre site. The other two strategy elements were; 'keeping promises on value and quality' and 'new services and ways of working through partnerships.'
- We saw a leadership team for the cancer centre with a unified vision of the requirements for the future. Whilst the leadership team were able to discuss and articulate their vision for the service, we were unable to see this as a single plan with trust wide sign off. This meant that the plans were not fully recognised by the board.
- There was commitment to the achievement of a single aim; but lack of overarching strategy to describe the steps required.
- There was general consensus that the facilities were unable to provide the level of care required by the service.
- Clinical activity was increasing at approximately 5% per year. Senior management told us they monitored this regular it the QIT meetings. This informed their longer-term plans for service development.
- The land that Mount Vernon Cancer Centre was built on was owned by another trust and leased by East and North Herts NHS Trust. The management team told us that key to their longer term strategy for the site, they had been working at trust level to renegotiate the lease

to allow ownership of the site to change to East and North Herts NHS Trust. This would allow the development of the site to be driven by the East and North Herts NHS Trust. Staff told us there has been much discussion about building a new cancer centre but no definite decision had been made.
- We saw the trust brief to staff (September 2015) sent electronically, that updated staff on the latest position. It was clear from this, and from our discussions, that much work was being undertaken to resolve this issue.
- The management team were fully aware of the geographical limitations of the catchment area. The very large geographical catchment meant that patients had long travelling distances and times.
- There was overnight accommodation for patients whose journey was long and who had to attend regularly.

Governance, risk management and quality measurement

- Monthly management meetings were held. At these, complaints were reviewed and considered. Both responses to complaints and the themes and trends were discussed. We looked at the responses that the service had made to patients complaints. We saw that they were well considered and that the service responded appropriately.
- The service held monthly management meetings where incidents were discussed. Trends in incidents were also examined. Action plans were discussed and agreed. Following the meetings, emails were sent to the teams to share lessons and actions with them.
- We saw reports of an incident where a patient was transferred to another trust urgently because their condition had deteriorated. Following this, the management team reviewed the incident. Procedures were improved to reflect a better response and training to staff was also given.
- The service held monthly quality improvement and business planning meetings (called QIT). This allowed the management team for the service to focus on quality development. At this meeting, performance of a range of indicators was discussed and plans were developed to improve the quality of the service.
- Smaller QITs were also set up to lead on individual projects. This ensured progress was maintained and staff were engaged.
- The service held quarterly morbidity and mortality (M&M) review meetings. These were led by the divisional director. All deaths in the service were recorded.
- Senior clinicians in the service described how they were aware of a 'ceiling of care'. They described clinical care they were proud of, but also described how they realised their limitations. They recognised that some care was best provided in specialist units, even though they were not attached to a main acute hospital. They transferred patients out to other centres (often London teaching hospitals) for care that MVCC was not able to provide.
- The risk of failure of the gamma camera was recognised by the management team. For those patients requiring routine bone scans, alternative providers for bone scans had been identified and the management team had a plan in place for access on another provider's site should this be required. For patients requiring high dose radioactive iodine, the plan was less clear. Patients could not be transported between hospitals after their radioactive iodine dose and the management felt they would have to cease this work if the gamma camera failed.
- Local and corporate risks were recognised, recorded and mitigated on the hospital's risk register, particularly with regards to equipment failure.

Leadership of service

- The trust board held its board meeting on alternating sites. Every fourth meeting was held on the Mount Vernon Cancer Centre site. Trust management told us this gave them an opportunity to be present on the site and accessible. Staff we spoke with had differing views of the increased visibility this gave; with staff in clinical facing roles describing that they saw executive team members more often than staff in support roles (e.g. radiotherapy physics).
- Staff had welcomed the increased visibility of the chief executive in the cancer centre over the previous few months. Staff told us they valued this and hoped it continued.
- Staff told us that the divisional management team were highly visible and many staff we spoke with could identify divisional management team members and a recent time when they had seen them.

- Many staff we spoke with described a positive culture of supportive management. They described a clear leadership of the service in which they had significant confidence. Staff described an organisation that they felt proud to be part of.
- The trust hosted the national NCRI Radiotherapy Trials QA Group.
- We regularly heard of improvements in the service over the past three years. Staff spoke positively about the service leadership in supporting this.
- Approximately two years ago, the trust introduced an improvement opportunity called ARC (Accelerate, Refocus, Consolidate). This was designed to support service improvement and engage staff on taking ownership of their local improvement programme.

Culture within the service

- The trust had developed a people strategy that covered the period 2014-2016. This strategy set out three ambitions for the culture of the service; these were: 'Developing the Mount Vernon Cancer Centre site:' 'Keeping promises on value and quality' and; 'New services and ways of working through partnerships'.
- These were underpinned by five values, which were:
  - We put patients first
  - We strive for excellence and continuous improvement
  - We value everybody
  - We are open and honest
  - We work as a team. These values had an acronym, PIVOT.
- Through observation and discussion with staff, we saw that members of the clinical teams at all levels embodied those values in their work.
- We saw that while the staff had a strong affiliation to the Mount Vernon Cancer Centre brand; the affiliation to the East and North Herts NHS Trust was less strong.
- Staff described, and we saw, a strong team working and a culture of mutual respect. We saw staff communicating well within the different professional groups and we saw that people respected each other's professional contribution. For example, in the radiotherapy physics planning section we saw that there was a clear allocation of roles and that clinicians who attended to planning, to contribute to or sign off the plan, did so as part of a wider treatment planning team.
- Staff told us they liked working at the trust. We heard many comments such as: "Nice place to work;" "People are really nice;" "Small site, friendly;" "Makes you feel proud."
- Staff employed through an agency as temporary staff also told us that: "The agency say it's a nice place to work."
- We saw that in planning the location of the SPECT scanner, the location of the scanner in the nuclear medicine service may not have been the best choice due to the age of the building. We saw the radiotherapy management team work as a single team to find the best location.
- Staff told us that it felt that real progress had been made in the last couple of years and there had also been a culture change. A driving force for change was achieving the IMRT and IGRT national targets.

Public engagement

- The service encouraged patient engagement through the use of comment cards.
- There was a patient experience committee that was held regularly. This was chaired by a non-executive director. It included six patient representatives and considered comments and complaints received by the services.

Staff engagement

- Communication to staff was through regular newsletters.
- Specific meetings were set up by team leaders to engage staff on specific issues.
- Staff were encouraged to populate the staff meeting agenda to ensure that it covered topics that were meaningful to them.

Innovation, improvement and sustainability

- Staff were proud of the developments in the service, and told us there was an effective process for introducing new things.
- The trust had developed a Radium-223 service to treat patients whose cancer had spread to their bones The team accessed funding through research and the cancer drugs fund, to support the development of this service.
- Four therapeutic radiographers had been trained to undertake breast radiotherapy treatment mark-up. This is a task historically undertaken by medical staff.

Radiotherapy

- Funding had been secured to develop a podcast for patients undergoing head and neck chemo-radiotherapy. There were a number of podcasts on the Lynda Jackson website which patients could access on a number of topics regarding head and neck radiotherapy and it was planned to produce more of these
- Radiographer-led fiducial marker implants were undertaken in the brachytherapy suite.
- In outpatients, there was a clinic pharmacist in place; this allowed the team to pick up issues within the outpatient service and making interventions much quicker. This included managing medicines of patients attending for radiotherapy.

Outstanding practice and areas for improvement

Outstanding practice

- The radiotherapy service provides IMRT (Intensity Modulated Radiotherapy) to a higher percentage of patients than the England average. The service provided a good range in IGRT (Image Guided Radiotherapy). Together these are indicators of a high quality radiotherapy service.
- The radiotherapy service had a strong reputation nationally as a major contributor to clinical trials.
- The radiotherapy service was accredited to the ISO 9001 quality standard.
- The cancer centre is one of the top ten centres in the country for research and innovation.
- Care shown to patients undergoing chemotherapy was outstanding.
- Effective multidisciplinary working was evident throughout all departments.
- All staff were proud to work for MVCC and many described it as a special place to work.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that patients who require urgent transfer have their needs met to ensure their safety and that there is an effective process in place to handover continuing treatment.
- Ensure there is oversight and monitoring of all transfers.

Action the hospital SHOULD take to improve

- Consideration given to patients' needs are responded to when they are transported outside the building.
- Consideration should be given towards using one system for recording and administrating blood transfusions. Standards of hand-washing did not meet the infection control national guidance standards.
- Consider that urgent transfers out of the hospital are recorded on the trust's incident reporting system, so that there is an oversight for the reasons.
- Consider ways of resolving long waits in outpatients and for chemotherapy.
- Consideration should be given to unwell patients having to queue for their outpatient appointments.
- Consider a more effective way of ensuring the environment in MSH is clean and safe.
- Ensure that all staff are aware of their responsibilities with regards to DoLS and MCA.
- Consider collecting information of the percentage of people who achieved dying in their preferred location.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12. (2) (a)(b)(h)(i) Care and treatment must be provided in a safe way for service users.** How the regulation was not being met: The provider did not operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider did not operate effective systems designed to ensure that patients who required urgent transfer had their needs met to ensure their safety. There was no process in place to ensure their continuing treatment.

Regulated activity	Regulation
Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance** How the regulation was not being met: The leaders had not recognised the risks of transferring acutely unwell patients out of the hospital via an ambulance. Urgent transfers out of the hospital were not recorded formally.