

Cancer Centre London LLP

Quality Report

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

Ratings

Overall rating for this location		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive?		Outstanding	
Are services well-led?		Good	

Summary of findings

Letter from the Chief Inspector of Hospitals

This was the first comprehensive inspection of Cancer Centre London LLP, which we carried out on 24-26 May 2016. The inspection reviewed how the centre provided medical care and treatment, in this case chemotherapy and radiotherapy, to patients attending on an outpatient basis.

The Cancer Centre London LLP offered complex investigations such as computerised tomography (CT scanning) and if patients required additional investigations for treatment planning such as magnetic resonance imaging (MRI), this was available at the provider's nearby location, Parkside Hospital. CQC had inspected Parkside hospital, to which oncology patients could be admitted for inpatient treatment, at the same time as the CCL inspection. Patients also had the choice to undertake some of their treatment planning investigations at any other private provider if they preferred, or if they needed a type of scan not available at Parkside Hospital.

Overall, we have rated Cancer Centre London LLP as good. We found the centre was good in four of the key questions we always ask of every service relating to safe, effective, caring and well led. We found the service to be outstanding in its responsiveness to patients.

Are services safe at this cancer centre?

- We saw a culture of safety among staff and effective systems and protocols to protect staff and patients from avoidable harm because staff understood the potential risks of cancer treatments.
- Anti cancer drugs were prepared in a germ free environment and were prescribed and administered safely.
- The radiotherapy department and chemotherapy service was certified to the ISO9001 Quality Standard and held cancer standards CHKS accreditation, which required clear policies, protocols and work instructions to ensure safety.
- Staff reported incidents which were investigated, feedback was given and learning applied to prevent the re-occurrence. If something went wrong, staff were open and transparent with patients and families.
- Staff we spoke with had a good understanding of safeguarding.
- There was always a registered medical officer (RMO) on duty when the centre was open and there were enough trained nurses and radiotherapy staff to ensure patients were safe from avoidable harm.

Are services effective at this cancer centre?

- The centre provided effective care because patients' care and treatment was individually planned in line with good practice, national guidelines and legislation. Any changes to guidelines or policies were signed off by the medical advisory committee (MAC) which met quarterly.
- The MAC regularly reviewed doctors' practising privileges.
- There was some participation in national audits, and staff audited many aspects of the centre's work. We saw action taken in response to audit results.

Are services caring at this cancer centre?

- We saw staff demonstrate kindness and compassion in dealing with patients and their families. Patients praised staff for their care and attention. They said they had confidence in staff treating them and were involved in making decisions about their care.
- A high proportion of patients would recommend the centre to their friends and families.
- There was access to emotional support for patients who needed it.

Are services responsive at this cancer centre?

- The service was extremely responsive to its patients and their families.
- Waiting times for radiotherapy treatments were minimal.

Summary of findings

- Appointments were made to fit around patients' preferences and other commitments, for example if they were working or had carer responsibilities.
- Patients waited under an hour for their chemotherapy treatment after their medical consultation.
- Patients had individualised treatment plans, and there was a wide range of information as well as local support available to them.
- There had only been three complaints, all minor, about the service in the last year. If a patient or relative had a concern, staff aimed to resolve it at once.

Are services well led at this cancer centre?

- Staff were clear about the importance of providing safe, high quality care to patients and were proud of the personalised care they offered.
- There was an effective clinical governance structure, risks were identified and acknowledged and action plans were put into place to address them.
- Care was evidence based and action plans were regularly reviewed.
- The MAC and the registered manager monitored performance and reviewed practising privileges regularly.
- Although a small centre, they had developed some innovative treatment techniques.

We saw some areas of outstanding practice including:

- Heart sparing radiotherapy which had won the LaingBuisson award for innovation in technology in 2015.
- A radiotherapy technique for controlling Dupuytren's disease had excellent results.
- The service was outstanding in its responsiveness to the needs of its patients.

However, there were also areas of where the provider needs to make improvements.

The provider should:

- The provider should consider improving temperature control in the chemotherapy suite and its clinic room, and review the suitability of the second chemotherapy clinical room for treatment.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating Summary of each main service

Good



We found the cancer treatment services provided at CCL to be good.

- The service was outstanding in its responsiveness to the needs of its patients.
- Waiting times for radiotherapy treatments were minimal.
- Appointments were made to fit around patients' preferences and other commitments, for example if they were working or had carer responsibilities.
- Patients waited under an hour for their chemotherapy treatment after their medical consultation.
- Chemotherapy, radiotherapy and other treatments were planned and coordinated safely and effectively. There was a multidisciplinary team work ethic and treatment was discussed and decided in multidisciplinary meetings (MDTs).
- The radiotherapy department benchmarked aspects of its work with other radiotherapy units in the London, Sussex and Kent area, to improve local practice and improve patient safety.
- Patients were protected from avoidable harm because staff understood the potentially serious risks of treatment. Incidents were reported, investigated and lessons were learned and shared with staff.
- Patients were given timely support and information to help them cope emotionally with their treatment and condition. Compliments about the service far exceeded concerns raised.
- All professional groups of staff were supported with mandatory training and continuing professional development (CPD). Staff felt valued and listened to.
- Electronic patient records enabled staff to access clinical information, protocols and procedures to support the delivery of evidence-based care.
- Electronic prescribing of chemotherapy drugs supported safe practice.

Summary of findings

- We saw staff being caring and compassionate in their interaction with patients and their relatives. Patients, and their relatives or friends were involved in their treatment (with the patient's consent) and patients were complementary about the care they received.
 - The leadership team were visible and approachable. Key risks were identified on the risk register.
 - There were quality improvement meetings at all levels. Staff felt well supported.
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Summary of findings

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Good 

Cancer Centre London

Services we looked at

Medical care;

Summary of this inspection

Background to Cancer Centre London LLP

Cancer Centre London LLP opened in 2003, and was then known as the Parkside Oncology Clinic. In 2010, the facility was re-branded the Cancer Centre London LLP (CCL). It is managed by Aspen Healthcare Ltd but part-owned by a limited liability partnership of 11 consultants.

CCL is a specialist oncology day treatment centre registered to treat cancer adult patients (18 years and older). It is located in Wimbledon in the London borough of Merton and mainly treats private patients from south west London.

The centre offers a range of oncology services, radiotherapy, chemotherapy, nuclear medicine and patient support services such as complementary therapy; dietitian; psychosocial services and a patient information

centre. These support services are intended to ensure a holistic personalised approach to the care of patients undergoing treatment. The multi-disciplinary team at CCL comprises medical and clinical oncology consultants, on-site resident medical officers, pharmacists/pharmacy technicians, oncology nurses, radiographers, physicists, healthcare assistants, an outpatients team, an information centre co-ordinator and porters.

There are no inpatient beds at CCL. However, there is a formal arrangement for CCL patients needing inpatient treatment to be treated on a ward at Parkside Hospital, which is under the same management. The ward is specifically for oncology patients and has oncology trained nurses. Both CCL and Parkside Hospital have the same registered manager, Mrs Hilda Bradbury.

Our inspection team

Our inspection team was led by:

Inspection Lead: Roger James, Inspection Manager, Care Quality Commission

The team included a CQC inspector, a consultant clinical oncologist, a diagnostic radiographer and an expert by experience.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to peoples' needs?
- Is it well led?

Before visiting we reviewed a range of information that the centre had shared with us. We held a focus group with

staff on 18 May 2016 to allow them to share their views with the inspection team. These included clinical and non-clinical staff. Patients were invited to contact CQC with their feedback.

We met with senior managers as well as service leads and clinical and non-clinical staff at all levels. We visited all clinical areas. We also spoke to patients and their relatives we met during inspection. Our inspectors and specialist advisor spent time observing care, and we reviewed patient's records where necessary, to help us understand the care that they had received.

Summary of this inspection

Information about Cancer Centre London LLP

The centre is registered for diagnostic and screening procedures and treatment of disease, disorder and injury.

The registered manager is Hilda Bradbury. The same individual is also registered manager at Parkside Hospital with which CCL works closely.

There are 38 doctors working under practising privileges. There are 52 staff and 10 bank staff.

During 2015, there were 6249 medical procedures at the centre, 3561 radiotherapy sessions, 2079 chemotherapy treatments and 609 nuclear medicine examinations and treatments.

111 incidents were reported during 2015. 74 of these were clinical incidents.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Medical care

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

Are medical care services safe?

Good 

We rated safe as good. This was because:

- We saw evidence of a good culture of safety among staff who recognised the potential dangers of anti cancer drugs and radiation. There were effective systems and protocols to protect patients from harm. Staff understood risks and had a clear objective of providing care and treatment that kept patients safe from avoidable harm.
- Cytotoxic drugs were prepared aseptically (in a germ free environment), prescribed and administered safely and patients were given clear information about potential side effects and when to contact the hospital if they were to experience specific symptoms.
- The radiotherapy department benchmarked data against other London, Sussex and Kent radiotherapy providers, NHS and private. It was accredited against the cancer standards by CHKS and certified to the ISO9001 Quality Standards which required clear policies, protocols and work instructions to ensure safety.
- Staff reported incidents which were investigated, feedback was given and learning applied to prevent the re-occurrence. If something went wrong, staff were open and transparent with patients and families.
- Patients' care needs were assessed, planned and delivered in a way that maintained their safety. A doctor was always on site to review patients regularly, and provide support when patients felt unwell.
- Staff had completed mandatory training updates, and were knowledgeable about how to protect vulnerable patients.

However,

- The clinical room and the dirty utility room in the chemotherapy suite were both too small for purpose and cluttered. It was difficult to maintain the clinical room at an even temperature in warmer weather.
- The overflow chemotherapy room was not fully equipped for clinical use even though staff told us it was sometimes used by patients.

Incidents

- In 2015, a total of 111 incidents had been reported at CCL. More incidents were related to chemotherapy (including pharmacy and pathology) than for radiotherapy. This pattern was in line with expectations. All incidents in 2015 were rated low/no harm and were reported on the electronic system for incident reporting used across Parkside Hospital and CCL (within walking distance) , to which all staff had access. Incidents were initially discussed locally and later at joint CCL/Parkside Hospital quarterly health and safety meetings. Clinical incidents such as delayed chemotherapy were discussed at the Medical Advisory Committee (MAC). All staff we spoke with knew what incidents should be reported, and how to do this.
- There had been no never events and no serious incidents requiring investigation in the last year.
- The radiotherapy service used an incident reporting system that was widely used by radiotherapy units to record incidents (Qpulse). This facilitated benchmarking with other radiotherapy services. Incidents were coded using the 'Towards safer Radiotherapy' classification system. Clinical incidents graded 1-4 were also reported on Parkside Hospital's electronic incident reporting

Medical care

system. Non-clinical incidents in radiotherapy were only recorded on the radiotherapy department's system. We reviewed the non-clinical incidents which were managed satisfactorily.

- Radiotherapy reported incidents were in line with the Ionising Radiation (Medical Exposures) Regulations 2000 (IR(ME)R) and the guidance by Department of Health and the Health and Safety Executive. These required reports to be made to the IR(ME)R team at the Care Quality Commission (CQC). CCL had reported one incident to CQC in May 2015, mainly as a learning process; a teenager had been treated inadvertently and this was outside the provider's licence. No further action had been required, but the learning from this was to ensure that date of birth was flagged on the computer system to ensure staff checked this.
- An example of learning from an incident in radiotherapy was when a patient was treated at the wrong energy level. In response to this incident, the set-up process had been changed so one radiographer now called out the beam energy and awaited confirmation from the second radiographer before switching on the machine.
- A few patients treated at CCL died as inpatients at Parkside Hospital. Mortality and Morbidity meetings were not routinely arranged to review deaths and their primary causes, however all deaths were reported in the clinical governance report and reviewed by the Medical Advisory Committee. None of the deaths in the previous year were unexpected.

Duty of Candour

- Staff told us they were open and transparent with patients and their relatives should anything go wrong. Staff told us of an incident where one patient was underdosed when treated with radiation. The patient was informed, in line with the duty of candour policy, and the underdosed area under treated was treated with a supplementary dose at the end of the course of radiotherapy.
- A Duty of Candour study day had been held, the policy had been updated and staff reminded that action must be taken to inform patients of harm even when no complaint had been recorded.

Cleanliness, infection control and hygiene

- The waiting areas and the clinical treatment areas were visibly clean and tidy. Chairs were covered in easy to clean materials, which allowed appropriate levels of hygiene to be maintained throughout the working day.

- The centre had a lead infection prevention and control (IPC) coordinator and a member of staff in each unit was a point of contact for all the IPC procedures and had dedicated time for this role. Quarterly audits had been introduced as well as monthly hand hygiene audits which showed strong compliance.
- In the chemotherapy suite we saw nurses clean down the equipment, including chairs, after patient use. Staff used stickers to show when they had cleaned clinical items, allowing staff to be confident the equipment had been cleaned. We saw staff using hand gel between each patient contact.
- Control of Substances Hazardous to Health (COSHH) assessments were carried out. We reviewed the assessment for 2016 which was comprehensive.
- All staff we spoke with understood the safety procedures for dealing with cytotoxic spillages: the decontamination of surfaces and individuals, the use of the Cytotoxic Spillage Kit (CSK) and of the purple cytotoxic sharps bin to dispose of contaminated materials and equipment. Staff had experience of a recent minor incident when a pump fell on disconnection, although there had been no significant spill.
- Staff could explain the additional precautions for dealing with body fluids that might be contaminated with cytotoxic matter, double flushing of toilets and the need to place potentially soiled linen in separate laundry bags. We saw signs on display about dealing with cytotoxic waste. Eye wash was available, with access to running water. There were separate toilets for patients having different modalities of treatment.
- We noted that there had been three cases of campylobacter identified in CCL patients although no link had been identified between the cases. This common bacterium is not unusual among patients with compromised immune systems, so were not unduly concerned. All new patients were screened for meticillin resistant *Staphylococcus aureus* (MRSA). MRSA is a bacteria that can be present on the skin without causing infection but can be a common cause of infections and which is resistant to many antibiotics.
- We saw staff were 'bare below the elbow' when in clinical areas, in line with the centre's policy.

Medical care

- We reviewed the policy on waste and saw clearly marked bags for clinical and domestic waste. Posters about segregation of waste and soiled linen were on display. Sharps bins were clearly labelled and records were kept.
- We noted that the laundry trolleys awaiting collection outside the building were in an unlocked area even though some bags might contain contaminated linen. On one day of our inspection, the padlock on the hazardous waste collection area was not locked.

Environment and equipment

- Care and treatment that protects patients from avoidable harm is particularly vital in cancer treatment, both for patients and staff as there is considerable potential for harm in many cancer treatments.
- One linear accelerator was in routine use and its full potential was gradually being rolled out. CCL staff had, in 2016, begun to offer stereotactic treatment for targeting tumours in the lung and brain that required patients to be immobilised. Before this, a stereotactic development group had been set up to establish and implement stereotactic radiotherapy treatment. We saw from the minutes of this group that a measured approach was being taken to the introduction of new treatments, including appropriate training.
- Access to the chemotherapy suite and other areas was secure and staff used swipe cards to enable access to clinical areas. Chemotherapy was only administered in designated areas and during normal working hours.
- Staff told us there was enough medical equipment, for example intravenous pumps, to maintain effective care. All medical equipment was tested and calibrated annually, or more often if required.
- Resuscitation equipment was available on each floor and readily accessible. We saw evidence of weekly checking of this trolley, including ensuring that consumables and drugs within the trolley were in date. We found no out of date or missing items. The defibrillator was checked. There was a smaller resuscitation trolley and defibrillator in the consultation suite, which were also seen to have been checked.
- Radiotherapy equipment was located in the basement, as is common due to the combined weight of the machines and their treatment rooms. The head of physics maintained an up to date inventory of radiotherapy equipment. We reviewed maintenance schedules which showed equipment was maintained and quality assured to ensure environmental safety in line with the Institute of Physics and Engineering in Medicine (IPEM) National guidelines. Radiographers carried out daily quality checks such as on consistency of dose calibration. The physics team also carried out quality assurance checks to keep machine downtime to a minimum. This work normally took place in the evening or weekends so as not to disrupt patient treatment. Radiotherapy treatment quality control of IMRT and VMAT patient plans was often done at weekends; this involves simulated delivery of treatment to a phantom in which measurements are made.
- The centre had a radiation protection adviser from a London hospital trust. The lead physicist at the cancer centre chaired the Radiation Protection Committee for the Aspen Group.
- Medical physics staff told us they were alerted to any safety issues related to the equipment through regular updates and customer bulletins from suppliers and from Public Health England (PHE) and the Medicines and Healthcare products Regulatory Agency (MHRA). This ensured they could respond to any equipment safety issues promptly.
- The radiotherapy service was certified to the ISO9001:2008 quality standard and assessed by an external auditor annually. No issues had been raised in the last inspection. The service had been ISO accredited for more than nine years. The quality system (QS) ensured that radiotherapy was delivered as intended and in accordance with protocols.
- Staff told us a second linear accelerator was now rarely used and that consideration was being given to replacing it. National guidance recommends that providers should ensure each linear accelerator is in operation for a maximum of 10 years and that the replacements are planned in a timely manner. The Primus linear accelerator was installed in 2003 and the service was aware that replacement parts would not be available after 2017. This machine did not have the capability to treat volumetric modulated arc (VMAT) and stereotactic treatments (these are fast, accurate methods of radiation treatment) and could only support treatment of patients using active breathing control by manual radiographer operation.
- Absolute doses of radiation and overall dose distribution for each patient were monitored using in vivo dosimetry to provide immediate feedback on dose deviations.

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- Evidence of employer liability was on display, and of CQC registration.
- We saw the environment agency permit for the disposal of radioactive waste from the nuclear medicine area, and evidence that this was adhered to.
- The clinical room and the dirty utility room in the chemotherapy suite were both too small for purpose and cluttered. The clinical room became overheated so the door was often left open to avoid the room temperatures from rising to unsafe limits. There was no air conditioning in the chemotherapy suite; summer temperatures sometimes exceeded the recommended normal room temperatures causing a risk that some medicines normally stored at room temperature, might lose their efficacy. Staff told us that restrictions on alterations to listed buildings limited scope for improvement although a development plan was in progress.
- The accommodation was well maintained. The main chemotherapy suite was well lit and bright. The atmosphere was unhurried and relaxed. Cleaning checklists were completed by domestic staff.
- A second chemotherapy room that staff told us was used occasionally for unwell patients was not set up for immediate use. The first aid box contained a lot of bandages and dressings but lacked other items normally stored in such a box such as safety pins and disposable sterile gloves. The urine test pots in that room had passed their expiry date.
- The single room for a patient who needed to lie down for chemotherapy, or if patients were unwell, was also used as a storage area for the resuscitation trolley. This was not ideal as it meant patients were disturbed when staff needed to use equipment stored in that room.

Medicines

- Chemotherapy drugs were prescribed by doctors authorised to do so. All chemotherapy prescribing was on evidence-based electronic CCL pro formas.
- Pharmacy staff did not release chemotherapy drugs to nurses until a doctor had confirmed satisfactory results for patient's blood tests. Medicines were safely transported from pharmacy to the chemotherapy suite using standard protective equipment, yellow padded bags for cytotoxic drugs or a square box for transfusions.
- Only trained chemotherapy nurses administered cytotoxic drugs. They were aware of the vital importance

of safe handling of chemotherapy drugs and complied with Aspen policies and best practice in using personal protective equipment such as gloves and aprons, which we saw in use.

- There had been a practice of doctors making verbal requests for medicines to nurses. This contravened the provider's policy which stated that medicines orders could only be requested from RMOs and pharmacists. Managers were addressing this in discussion with staff.
- Controlled drugs (CDs) need special storage arrangements because of the potential for misuse. There were appropriate arrangements for storage of CDs but we noted that an audit in December 2015 had shown low compliance with weekly checks. Cytotoxic drugs were stored separately from other drugs in line with good practice and were for the use of named individuals only.
- Medication incidents had been consistently 10% of all incidents over the year to May 2016 which was within normal range.
- Fridge temperatures were checked daily to ensure that medicines requiring refrigeration were stored at the correct temperature.
- We found a blank prescription pad on a desk in an unlocked consulting room. This was unsafe practice as anyone finding it could potentially write a prescription.
- The pharmacy also provided an outpatient dispensing service.
- Medical gases were securely stored and locked.

Records

- CCL was reducing the reliance on paper patient records. Patient correspondence, referral request forms and checklists, such as the pre first cycle of oral or injectable chemotherapy checklist, were scanned and attached to the patient record. There were sufficient computer terminals to allow staff to retrieve information. Computer terminals were locked when left unattended to prevent unauthorised access to patient identifiable information.
- We checked six sets of notes of patients undergoing chemotherapy on Mosaiq (the IT oncology system at CCL), and on the corresponding handwritten drug charts. We found clear documentation of allergies, weight and height, assessments and National Early

Medical care

Warning Scores (NEWS). There was evidence of appropriate consent being taken, the use of a surgical safety checklist (for a patient who had had surgery) and evidence of clinical input by pharmacists.

- Where paper records were still in use, we saw all patient identifiable documentation was securely locked away when not in use in lockable fire proof cupboards.
- Doctors were not permitted to remove patient records from the hospital.
- Staff records were kept in well-organised paper files containing evidence of job description, training and appraisals.

Safeguarding

- Safeguarding procedures ensured staff understood their responsibilities to protect vulnerable adults and children. The director of nursing was the safeguarding lead for children and vulnerable adults, supported by the outpatient manager and the Parkside/CCL lead nurse for cancer who were all trained to level 3. Supervision for these staff was provided by an independent safeguarding advisor in a local authority.
- We reviewed the training records of staff working in CCL and saw safeguarding training was up to date: 96% of staff had completed adult safeguarding training by March 2016. Safeguarding training for children level 1 and level 2 was also 100% compliant. Staff completed eLearning every three years. Staff we spoke with understood their responsibilities for safeguarding and knew what to do if there was a concern.

Mandatory training

- Records showed that 98% of staff had completed mandatory training at March 2016. Mandatory training covered, for example, basic life support skills, prevention of blood clots, manual handling and pressure sores. Staff had dedicated time for learning which was recorded on an electronic system. There was a monthly team focus on each topic during which time staff updated their training.
- Some staff in each unit were trained in intermediate life support (ILS). All trained nurses in the chemotherapy suite had undertaken ILS training. In an emergency, staff would summon the resuscitation team from the main hospital.
- Staff in the radiotherapy department mandatory training included radiation protection and yearly IR(ME)R updates. Newly qualified chemotherapy nurses

had three practical assessments and were then re-assessed after three years, with self- assessment in between. Competences had been assessed as part of appraisal and revalidation since 2015.

Assessing and responding to patient risk

- A consultant Oncologist / Haematologist took the initial decision to initiate treatment in adult patients following discussion at the relevant multi-disciplinary team (MDT) meeting. Patients were reviewed regularly by their clinical oncologist over the course of their treatment.
- Nursing staff used the National Early Warning Score (NEWS) system to record and assess deterioration in patients. The NEWS score brings together physiological measurements such as temperature, blood pressure and pulse rate and the combined score indicates how far the patient's readings differ from the norm, and the level of escalation needed.
- Nurses assessed all chemotherapy patients before each treatment. This included checking any weight change (because the dose of chemotherapy is based on the patient's body mass index). Blood tests checked patients' red blood cell (RBC), white blood cell (WBC) and platelet count. If their RBC was too low, they might need a blood transfusion to prevent treatment from pushing these down to a dangerous level. Blood tests were also checked to determine how well the kidneys and liver were working, as these could lead to more side effects from the chemotherapy. The results were passed to the patients' consultant.
- CCL carried out blood counts on site and biochemistry tests were carried out Parkside Hospital. Parkside Hospital subcontracted histopathology and microbiology tests to external agencies. Patients' glomerular filtration rate (GFR), a test that uses radioactive materials or tracers to see how well the kidneys are working, was used for relevant patients before chemotherapy.
- Molecular diagnostics to identify the molecular alterations requiring treatment in some types of cancer were sent to an NHS cancer hospital for analysis.
- During chemotherapy treatment, nurses monitored patients, including observing the IV catheter sites for signs of swelling or inflammation, the rate of infusion and whether the patient showed any adverse symptoms. Nurses advised patients to notify them immediately on any symptoms of concern.

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- We reviewed the guideline on managing neutropenic sepsis which recommended treating patients with antibiotics within 30 minutes. Pharmacy audited treatment times for patients. All chemotherapy patients we spoke with confirmed that they were aware of possible serious side effects and risks of treatment. They had written information, to reinforce verbal information from clinicians, about any potentially life threatening symptoms required urgent treatment. Patients had a phone number to call, day or night if they needed assessment or treatment for sepsis. They were advised to come to the CCL in working hours or to Parkside Hospital out of hours immediately, if they had any of these potentially life threatening symptoms. We reviewed the CCL audit for patients admitted for sepsis and saw evidence that they also captured information about their patients who were admitted to other hospitals through A&E for suspected neutropenic sepsis.
- The radiotherapy service manager told us that risk assessments were carried out for individual patients whose treatment were different from protocol for any reason and for new techniques introduced into the department. Radiographers reviewed patients daily before their radiotherapy treatment so that any deterioration or reaction to treatment could be managed in a timely way.
- Staff told us procedures were in place to check whether female patients could be pregnant to comply with IR(ME)R. They said if there was any doubt a pregnancy test would be carried out before any exposure to radiation took place.
- Radiotherapy treatments and CT scans were protocol driven which ensured all patients received care and treatment that followed best practice standards. Variations in radiotherapy protocol could be signed off by the lead radiographer but final approval was given by the MAC.
- We saw appropriate and referenced systems for risk assessment of Iodine 131 therapy, a nuclear medicine treatment for an overactive thyroid or thyroid cancer to satisfy the conditions of Regulation 7 of the Ionising Radiations Regulations 1999 and Paras 44-49 of the Approved Code of Practice 2000 (HSE L121).

Chemotherapy Nursing staffing

- There were four chemotherapy nurses allowing a ratio of two patients to one nurse, although staff told us they

sometimes had three patients. One nursing post was covered by an agency nurse on a long term arrangement. We had no concerns about the use of agency staff.

- There were 1.8 whole time equivalent healthcare assistants.
- Staff told us they felt staffing was sufficient and the skill mix was appropriate. If there was ever a need to use the additional room with chemotherapy chairs, extra staff were provided. Nurses said they were sometimes asked to support radiotherapy patients, for example if there was skin reddening which took them away from caring for patients having chemotherapy.
- There was no onsite chemotherapy manager. The post had been advertised. It was covered in the interim by a sister from the oncology ward at Parkside hospital.

Radiotherapy staffing

- The radiotherapy service was staffed by three main professional groups: clinical oncology consultants, therapeutic radiographers and physicists, all of whom contribute in the multidisciplinary working on patient's radiotherapy pathway.
- Staff we spoke to felt staffing levels and skills mix was safe for the number of patients treated and the type of treatments delivered. The radiotherapy department used published guidance from the Society and College of Radiographers (ScOR), to benchmark radiotherapy staffing levels.
- There were 9.4 whole time equivalent therapy radiographers and an assistant practitioner.
- Some student radiographers undertook two week secondments to the department from Kingston University and City University as part of their training although the centre did not assess students and students did not work clinically independently. Staff followed the university training manual. No agency staff were used in radiotherapy.
- The medical physics team was made up of 6 physicists. All physicists were registered with the Health and Care Professions Council (HCPC) as clinical scientists. Their role was to undertake equipment quality control, to use computer software to devise a treatment plan, calculating the exposure and beam configuration, to treat the target to the dose prescribed by the oncologist, to develop new procedures and to maintain safety and quality. Two MSc students were on a four month secondment at the unit to work on digital artefact

Medical care

reduction software for the CT scanner to improve the accuracy of treatment planning in patients with prostheses present. There were two clinical technologist vacancies. The physics department staffing was based on the 'IPEM Recommendations for the Provision of a Physics Service to Radiotherapy (July 2009)' which took into account patient and equipment related, and departmental activities (radiation protection and quality system management).

Medical staffing

- The medical workforce was made up of 38 consultant clinical and medical oncologists who had practising privileges at the centre. Of these, 26 doctors had at least 10 patients a year.
- Consultants provided cover for their own patients 24 hours a day, seven days a week. They arranged cover from another consultant with practising privileges when they were not available. Most consultants worked at a number of other hospitals. The RMO told us that consultants were supportive, but some were occasionally hard to reach.
- A resident medical officer (RMO) was on duty every day during the hours the centre was open. The main RMO was an oncologist from an agency, but had worked at the centre for 8 years. If she was absent the agency provided another RMO. The role of the RMO was to review patients with complications from their treatment, prescribe medicines for patients to take home and also review acute patients presenting at the centre within working hours. This role included updating the electronic patient record for weekend staff. The RMO schedule was on display so staff always knew who was on duty. The RMO and nurses could contact patients' individual consultants for information or advice if necessary.
- If the centre was open for treatment at a weekend or in the evening, which happened occasionally if a patient needed daily radiotherapy treatments, RMO cover was provided through a locum. The RMO had prepared a comprehensive folder for locum staff with induction information and 'how to' guidance to ensure smooth handover. However, we did receive a comment from a patient who was dissatisfied with some locums who did not communicate well and seemed to lack experience.
- The RMO trained RMO staff in Advanced Life Support and was a medical appraiser for the Aspen Gr

- Outside working hours, cancer patients were reviewed by a RMO at Parkside Hospital which had 24 hour RMO cover, seven days a week.
- Four consultant radiologists worked in nuclear medicine. There was a vacancy for a nuclear medicine technologist.

Major incident awareness and training

- All services had business continuity plans. In chemotherapy, there was potential to arrange treatment at one of two local hospital trusts in the event of a significant problem at CCL.
- The radiotherapy service' business continuity plan stated that if there were delays to treatment, for example because of machine breakdown, treatment could take place later on a weekday or at weekends. RMO cover would be arranged, or consideration could be given to a different pattern of treatment – more treatments on a single day. In the past, there had been an arrangement to use facilities at a local trust but as this had never been utilised this agreement had now been allowed to lapse. In the event of failure of the CT scanner, another scanner was available at Parkside Hospital.
- Fire alarms were tested regularly. Fire equipment tests and electrical safety tests were in date.

Are medical care services effective?

Good 

We rated day cancer treatments as good for effective because:

- Patients care and treatment was individually planned at multi disciplinary meetings in line with good practice, national guidelines and legislation.
- Staff had access to induction, training and appraisal systems.
- There was evidence of local clinical audits and action at unit level. The centre provided some data to national audits.
- There were effective systems in place to ensure that staff maintained their skills as well as opportunities for development.
- There were effective systems to check the competence of medical practitioners with practising privileges.

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Evidence-based care and treatment

- Staff were aware of evidence-based practice and NICE guidelines, and told us they were notified of updates to these. All new CCL clinical guidance was discussed and ratified by the MAC. The centre also used international guidelines such as those of the American Society of Clinical Oncology (ASCO).
- All chemotherapy treatments were prescribed according to recommended practices with a written protocol containing indications, drug, dose, route, cycle length, and frequency, length of treatment, monitoring requirements, and requirements for dose adjustments. All chemotherapy protocols were evidence-based and approved by pharmacy, medical and MAC staff. Clinical audit was completed four times a year and a report was reviewed by the MAC.
- Most patients had chemotherapy administered through peripherally inserted central catheters (often called PICC or PIC lines or CVADs).
- To improve the accuracy of radiotherapy treatment delivered, image-guided radiotherapy (IGRT) was used in line with good practice. IGRT can be used to pinpoint the origin of the cancer while protecting the surrounding healthy tissue. 83.7% of patients having radiotherapy had IGRT. CCL did not use fiducials (small, implantable, typically gold, markers to help guide the placement of radiation beams during treatment).
- Patients with category 1 tumours were treated five days a week to meet the Royal College of Radiologist's (RCR) guidelines. We noted more than one occasion where the radiotherapy unit had opened on a bank holiday to comply with this.
- Radium treatment for advanced prostate cancer had been introduced in line with evidence-based research. Patient feedback, based on quality of life was good, but a doctor told us the treatment was expensive and did not yet have NICE approval.
- Stereotactic treatment that allowed the delivery of very accurate high doses of radiotherapy to patients with small tumours was being introduced gradually in 2016, on a case by case basis. The advantage for appropriate patients was that courses of treatment were much shorter with the same or improved outcome.
- Appropriate checking systems were used to ensure accuracy and correct alignment before patients started radiotherapy, and regularly during their treatments to ensure that any changes in the daily set-up were compensated for. This meant patients were receiving accurate treatments throughout the course of treatment, which resulted in improved outcomes. An audit of radiotherapy dosages in 2015 showed that doses were within 5% of standard levels.
- The RMO had carried out a cardiac audit which had changed practice. All patients due for chemotherapy now had an electrocardiogram (ECG) before treatment. If this was abnormal the patient would be referred either to a cardiologist on site for an echocardiogram to investigate the condition further, or to nuclear medicine for a MUGA scan. A multiple gated acquisition (MUGA) scan creates video images of the lower chambers of the heart that hold blood to check whether they are pumping blood properly. It shows any abnormalities in the size of the ventricles and in the movement of the blood through the heart. This was important because some cancer treatment may damage the heart.
- There was a process to audit activities against the national cancer standards and we saw action planned, and taken, to meet these where issues had been identified.
- The radiotherapy department participated in the Society of Radiographers national audit programme. For example in 2015 CCL participated in the Radiotherapy: radiographic workforce census and Therapeutic Radiography Workforce Questionnaire.
- The physics team were members of The Institute of Physics and Engineering in Medicine (IPEM) regional audit group for radiotherapy dosimetry which met six monthly. This group audited each others' equipment or techniques before they went into use. For example an NHS oncology centre had audited CCL's new LINAC in 2014 and the volumetric-modulated arc dosimetry (VMAT) in 2015. VMAT for stereotactic treatment (precise radiotherapy treatment) which was being developed on a site by site basis.
- Physicists had recently submitted publications to the British Journal of Radiology and Radiology, some of which had been published and others were awaiting submission. Three physicists had given presentations at conferences in 2015, including one on a novel technique of dose reduction in CT.
- The haemato-oncology department had full membership of the European Blood and Bone Marrow Transplant Group (EBMT) and the associated BSBMT as an autologous stem cell transplant centre. The Centre returned data on each stem cell transplant, which was audited as part of a national registry.

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- CCL linked to another private hospital for peripheral blood stem cell harvesting and patient outcomes were audited as part of that hospital's JACIE (Joint accreditation committee ISCT and EBM) accreditation process. CCL maintained a research / clinical database, containing anonymised details such as treatment, results, diagnostic and monitoring data on a group of 364 patients. This database was regularly audited to measure practice in relation to risk. Some doctors and the haemato-oncology clinical nurse specialist presented research papers at international conferences, for example Survival Outcomes for newly diagnosed myeloma patients compared to national and European outcomes 2015.
- At a local level patient outcomes were discussed and compared at the CCL's Acute Oncology Group (AOG) meeting.
- CCL accessed input and research from other national specialists units.

Pain relief

- Staff explained to us that if patients were experiencing pain, they would seek advice from the RMO. During our inspection we did not see patients needing pain relief.
- Radiotherapy treatment is a painless procedure so this was not relevant to radiotherapy.

Equipment

- The department had a linear accelerator that provided image guided radiotherapy (IGRT) and intensity modulated radiotherapy (these improve the way the radiation dose conforms to the tumour volume) and stereotactic radiotherapy, for small tumours requiring short high dose treatment. These technologies had been identified by national bodies as contributing to improving outcomes and survival.
- The pre-treatment area had a dedicated radiotherapy planning CT scanner, which was used for most patients before they received any radiotherapy. Three dimensional imaging from a scan defines the exact size, shape and location of the tumour. All scans were protocol driven to ensure consistency. Some patients needed other types of scan to guide treatment planning, such as an MRI scan which could be carried out at Parkside hospital, or another nearby private hospital. Where patients required positron emission tomography (PET) or integrated positron emission tomography/X-ray

computed tomography (PET/CT) as part of their radiation treatment planning, for example for lung cancer, this was done at another London private hospital.

- Staff were moving towards use of electronic portal imaging devices (EPID) on the linear accelerator for daily dose verification. The EPID dosimetry can be analysed with computer software before the treatment and, no significant additional dose is required for patients. The image can be saved in an electronic file for review.

Nutrition and hydration

- We reviewed a variety of patient information leaflets which gave clear instructions to patients about when they could eat or drink before their pre-planning and radiotherapy treatment appointments. During pre-treatment discussions with patients the radiographers told us they gave advice on eating and drinking during treatment.
- Patients were weighed each time they attended for chemotherapy treatment. If they were losing weight staff could refer them to a dietitian for advice on eating well, including supplements such as calorie loaded drinks, or to counteract the nausea that some patients experience.

Patient outcomes

- Treatment plans were based on best practice and all patient care was documented on their records. Treatment for many patients would not only involve chemotherapy, but might involve surgery, radiotherapy, symptom control or palliative care, depending on their needs.
- The main measurable outcome of cancer care is long-term survival. CCL wide patient outcomes were not measured for all aspects of treatment. Individual consultants kept their own records and there was no formal audit of breast outcomes although 400 patients had been reviewed by the breast MDT.
- Staff at CCL considered the quality of patient experience during treatment was very important and strove to make treatment a positive experience.
- The centre was one of the first to have an automated process for patients using active breathing control during radiotherapy treatment for breast or lung cancer. Patients were coached in a Deep Inspiration Breath Hold technique during the planning of their radiotherapy treatment. This technique reduced the amount of

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cardiac tissue in the radiation field, and hence reduced damage to the heart for patients having breast or chest wall radiotherapy, particularly the left breast. They had won an award for this in 2015.

- The centre treated Dupuytren's disease, a benign condition in which tissues in the hand cause stiff fingers that cannot be straightened. An audit of 150 cases treated, showed good results in using radiotherapy to stop the disease becoming more widespread. Their results were at least as good as results in Germany which was renowned for this treatment. A consultant clinical oncologist had presented a paper on Dupuytren's treatment at Therapeutic Radiation Oncology in 2016, and the Head of Physics had presented one on Dupuytren's Treatment Planning at the Royal Society of Medicine's Futures Conference, also in 2016.
- CCL used up-to-date technologies and techniques, for example IMRT, VMAT, stereotactic and CT scanning. This resulted in the delivery of more accurate treatments and the treatment of smaller areas which resulted in a better quality of life, with fewer side effects for patients.
- Skin audits were carried out on radiotherapy patients so that prompt action could be taken in the event of reddening of the skin. The audits showed results were within the expected range.
- The number of patients treated for cancers other than breast and prostate cancer were quite small. The radiotherapy manager told us that when treating cancers that staff were less accustomed to treating, consultants would be more involved in the initial stages of treatment.
- All patients requiring radiotherapy were treated within best practice guidelines from NICE. National guidance identifies the more gaps in treatment the worse the outcome; treatment gaps are more detrimental to patient outcomes than a short delay in initiating the course of radiotherapy. We reviewed an audit of patients treated in 2015 and saw that no patients were rested unless in exceptional circumstances and no Category 1 patients were rested. Of the six interrupted treatment courses not delivered within the RCR recommended number of days, four were compensated for by being treated on weekend and compensatory doses of radiotherapy were calculated using biological equivalent dose in line with good practice.

Competent staff

- We saw appropriate job descriptions for all disciplines of staff, and checks to ensure continuing registration with professional bodies. We reviewed the registration records of the radiographers. All staff were registered with the Health and Care Professions Council. There was a competency matrix for radiotherapy staff showing specialist training undertaken.
- New employees had an induction for the private hospital group and an induction to CCL. Two staff we spoke with told us the induction process was good and allowed staff to shadow a member of staff before working clinically. We saw completed induction checklists in staff folders. All staff had training in customer service.
- The radiotherapy service manager told us that there was a generous education budget which enabled staff in all clinical areas access to further education and study opportunities. Staff attended international conferences and training. Staff received training on new equipment from the supplier's applications teams. This ensured staff received high quality training on new equipment and the techniques the equipment could perform. We saw evidence of staff having equipment-specific training for the new linear accelerator and that staff had completed training and observed practice at other hospitals before new types of treatments were commenced at CCL.
- The physics staff had trained radiographers, nurses and pharmacists in performing scheduled and unscheduled audits. We saw documentary evidence of this and improvements in consistency of record keeping as a result.
- An agency nurse we spoke with told us they had completed an induction form which contained some policies and procedures which gave assurance that agency staff had appropriate induction, training and competencies to undertake their role. The nurse said she was included in CCL training.
- To maintain their competences all radiotherapy staff were required under IR(ME)R to sign each year to say they had read the local rules and risk assessment and we saw this had been done.
- Staff told us they received annual appraisals. We reviewed the appraisals of six staff members which were in line with national guidance.

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- There was an appropriate system to check doctors' appraisals and revalidation. 96% of appraisals were completed. We saw the annual appraisal and CPD folder for the RMO which followed national guidance.
- All new doctors had their admitting rights reviewed by the MAC members. We saw evidence that the practising privileges arrangements were reviewed biennially and a member of staff checked such issues as doctors' indemnity, disclosure and barring status and GMC registration. Consultants with practising privileges were able to include their work at CCL in their annual appraisal (such as incidents reported, complaints, number of procedures/consultations, length of stay and key KPIs per consultant). When making revalidation recommendations for doctors working at CCL, the responsible officer would write to all places that the doctor works to obtain information about their practice to check there were no causes for concern.

Multidisciplinary working

- Multidisciplinary Teams (MDTs), based on tumour types, decided on patient eligibility for systemic therapies (chemotherapy) or for radiotherapy. All new patients were assessed in an MDT. There was a solid tumour MDT and a breast MDT weekly. A Haemato-oncology MDT was held monthly because there were fewer patients. A weekly palliative care MDT at Parkside was led by a Clinical Nurse Specialist. Most MDT meetings were virtual rather than face to face and involved clinical oncologists, radiologists and physics staff and pharmacy as appropriate. Staff were exploring the possibility of joining a stereotactic consortium with some NHS hospitals.
- Physiotherapists were available to support patients with cancer related symptoms such as pain, stiffness or respiratory problems.
- We were told that all new developments in IR(ME)R were discussed at clinical and technical MDT meetings and records showed evidence on this. An IM(ME)R compliance map was maintained. Technical MDT meetings took place every four weeks and were minuted.
- Patient's side-effects were managed via referral to the relevant multi-disciplinary team. These include dietician, oncology physiotherapy, breast care nurse, lymphedema therapist, resident medical officer or the

patient's consultant. Side effects were audited weekly and documented on Mosaik oncology information systems. We saw nurses, pharmacists and therapists working in partnership.

- We saw that CCL worked well with external services. When patients reached the end of treatment information about the treatment provided was shared with the patient's GP. The centre followed up patients who had been discharged by telephone.

Seven-day services

- The radiotherapy and chemotherapy services were open for patients from 9 am to 5 pm. It was a day treatment unit, not a 24 hour unit.
- However, a 24 hour Acute Oncology Service (AOS) was maintained through arrangements with Parkside Hospital. Out of hours, patients with concerning symptoms related to their cancer could telephone Parkside hospital where the RMO on duty (24 hour cover) would give advice and could contact the patients' consultant and admit the patient, if necessary. Patients were given written information about this service at the start of their treatment. Part of the criteria for consultant practising privileges was that consultants were always available by phone or person, or would arrange appropriate alternative, named, cover if they were unavailable at any time.
- In addition to clinical and consultant arrangements, the senior management team had an on-call rota for advice and support out of hours

Access to information

- Policies we looked at were held on computer. Those we reviewed were current and referenced good practice guidelines and published research papers. All staff we spoke with knew how to access protocols and standard operating procedures. Staff told us there were enough computers available.
- Radiotherapy protocols did not show review dates and it was not clear if there was a regular review programme.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient consent to the specific planned treatment was obtained at the clinical consultation phase. Radiotherapy patients confirmed their consent at their pre-treatment planning scan and before treatment. All radiotherapy patients received a copy of their site

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specific consent form, outlining acute and long-term side-effects, after the patient's consent was confirmed by a radiographer. For radiotherapy the consent forms were specific to the planned treatment.

- The consent forms for chemotherapy were generic, rather than regime specific, but doctors recorded possible and less likely side effects in writing for patients.
- A blood transfusion audit had found that patients had not always been asked for written consent advising them of the side effects for blood transfusion. This had been reported to the oncology MAC and raised with relevant consultants to ensure that written consent was obtained in future. The organisation had added a reference to blood transfusion to their policy.
- Staff we spoke with were broadly aware of procedures for consent where patients lacked capacity. MCA training materials were on the NetConsent policy system and all staff were required to complete these. There was a Mental Capacity Policy to which they could refer. If a patient had mental health problems they could seek support from a nearby private mental health hospital.

Are medical care services caring?

Good 

We rated this service as good for caring because:

- Patients told us they their dignity was respected and they praised staff for their care and attention.
- The quarterly patient survey data confirmed that patients had confidence in staff.
- Patients' individual physical and emotional needs were considered and met.
- Patients and relatives reported feeling involved in planning their care and treatment to the extent they wanted to be, and said they received clear information about their condition and treatment from their oncologist. They said staff delivering their treatment explained the processes.
- Most staff we spoke with had a clear understanding of and empathy for the needs of patients and their friends and families and went out of their way to provide help and support.

Compassionate care

- We spoke with eight patients attending for different treatments who were all very complementary about the kindness and helpfulness of staff. They praised the positive outlook of staff.
- We saw clinical and non-clinical staff treating patients in a professional and considerate manner. Patients commented on the positive outlook of staff.
- All the staff we spoke with were enthusiastic about the service they provided to ensure patients received good-quality care that they would want their own families to receive.
- The NHS Friends and Family test was used to record patient feedback. Current results showed that 99% (of 89 patients) would recommend the centre as excellent or very good. The hospital also collected evidence of patient experience through their own patient feedback questionnaire and we saw that showed a high degree of satisfaction with 100% of patients recommending the service. Personalised attention was one of the staff values.
- The availability of different waiting areas for different treatments gave patients a degree of privacy.
- Comments from patients during our inspection included "The staff are unfailingly cheerful, polite and helpful with appointments and any queries"; "The blood test nurses are efficient and gentle"; "My consultant provides clear advice in a considerate and measured manner to minimise any concerns"; "The chemo unit is a lovely, relaxed environment and very clean" and "I was listened to by everyone; My needs were responded to with the right care and treatment at the right time".

Understanding and involvement of patients and those close to them

- Patients we spoke with said that before treatment, the consultant discussed potential side effects them such as the risk of colitis, dehydration, or reduction of thyroid function and potential impacts on pregnancy or fertility. Patients told us they were given time to reflect on the options and decide on treatment.
- Two relatives told us they felt they were kept fully informed, and the information given was tailored to fit their and the patient's needs.
- Doctors considered patient choice an important component of the decision-making process, and seek to ensure patients understand the benefits and side effects as well as the level of uncertainty.

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Emotional support

- All patients had access to confidential psychological support during the course of their treatments.
- Patients mentioned that they valued the small size of the centre where they got to know the staff, and two patients praised staff sensitivity to their state of mind.
- Staff could contact the chaplaincy if requested by a patient.
- Nurses directed patients to relevant support groups internally and externally, and to websites.
- Evidence based relaxation therapies were available and we saw this being used during a patient's chemotherapy session.
- There was support for staff from a counsellor who came in once a month as well as online staff support.

Are medical care services responsive?

Outstanding



We rated the centre as outstanding for responsiveness to patient needs and wishes because:

- Waiting times for radiotherapy treatments were minimal.
- Appointments were made to fit around patients' preferences and other commitments, for example if they were working or had carer responsibilities. Other appointments with dietitians, psychologists or complementary therapies could often be arranged to coincide with treatments.
- Patients waited under an hour for their chemotherapy treatment after their medical consultation.
- Each patient had an individualised treatment plan.
- Patients experienced continuity of care both from medical staff, nurses and non-clinical staff because staffing was stable and the service was small.
- There was a very wide range of information available to patients to supplement what they were told by clinical staff, as well as talks for patients and their friends and families.
- Staff aimed to resolve concerns straight away in discussion with the patient or family. There were only three formal complaints in 2015, all minor. Both formal and informal complaints had been acted on to prevent a recurrence of the concern.

Service planning and delivery to meet the needs of local people

- Most patients were from south west London, but a few were from overseas. All patients received a detailed information pack about the centre before their treatment started.
- Staff told us, and patients confirmed, that was flexibility in appointment times to meet the needs of patients who were working or had care responsibilities.
- In common with other private hospitals, patients chose their own consultant and location of treatment.
- Pre-treatment appointments enabled patient to prepare for their chemotherapy and supportive treatments such as blood transfusions, blood tests, injections and other intravenous therapies or radiotherapy.
- Patients having a course of chemotherapy could choose to have blood tests on the same day as their treatment, or the day before. Those choosing to have tests on the day did not have long to await the results and see the consultant for confirmation that treatment could proceed. Patients told us the consultant informed them of their test results verbally and the test results were also sent in writing.
- All patients requiring radiotherapy received it within best practice guidelines and no patients were rested unless in exceptional circumstances. National guidance identifies the more gaps in treatment the worse the outcome; treatment gaps are more detrimental to the patient outcome than a short delay in initiating the course of radiotherapy.
- An Information centre was located in the entrance to CCL and had been awarded the Macmillan Approved Quality Cancer Environment accreditation. This had booklets on a wide range of cancers, chemotherapy induced symptoms, services available to support the effects of living with cancer and dealing with its emotional effects. Some were written by the Macmillan cancer charity. There was also information about local self-help groups. Monthly lectures were arranged on health related topics. Patient surveys indicated that patients appreciated this resource.
- Clinicians saw patients being treated at CCL for check-ups. A few doctors held their clinics in the evening.
- CCL had an ambulance for transporting patients from the Cancer Centre to Parkside Hospital in case of need, so there was minimal delay in transfer.

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- Patients and those accompanying them had access to free hot drinks and fresh water in the waiting areas.

Access and flow

- Of the 202 patients treated with radiotherapy in the previous year (Oct 2014 to September 2015) the latest audit available, 99% were treated within the RCR recommended number of days or compensated for. Of these, 98 patients had at least one treatment interruption. We noted that in February 2016 the treatment of 16 patients had been delayed by machine breakdown, although only 9 patient treatment delays had been reported to the clinical audit committee. Staff were unclear why the numbers differed.
- Sufficient time was scheduled between patient appointments both for consultation and treatment so as to avoid long waits. Patients attending for treatment each day would have an allocated appointment time and patients we spoke with said they were almost always seen on time.
- Patients having radiotherapy were quickly rescheduled in the event of delay caused by machine breakdown.
- We reviewed the monthly radiotherapy waiting time audits and considered that waiting time from the decision to treat to the start of treatment were longer for some patients than we might have expected in a private hospital. For example, in December 2015 seven patients out of 27 waited 19 or more days to start treatment. Staff told us it might typically take two weeks from CT scanning to start of IMRT or VMAT treatment of a prostate gland. for the plan to be prepared and signed off by the consultant. Breast patients typically started treatment three working days after simulation.

Meeting people's individual needs

- All radiotherapy patients received tailor-made care and treatment based on their individual treatment planning scans.
- Before patients came for treatment staff checked patient notes in case there were any specific needs of the patients, for example whether an interpreter was required, whether they had any hearing or visual impairment, or if they had a pacemaker. This meant treatment could be planned around the needs of the patient before they arrived.
- Interpreters were available, if required, through Parkside hospital. Staff told us there were a few patients from the Middle East so staff had been given simple Arabic

phrase books to aid communication when an interpreter was not available. This language fitted the patient profile. Staff said that if a patient needed an interpreter in another language this would be arranged.

- Three Clinical Nurse Specialists were available to support patients with the breast service, haemato-oncology and palliative care. This was a BUPA accredited breast care service. The nurses also ran clinics and could provide up to date information on the diagnosis and treatment of breast cancer.
- CCL offered a chaperone to patients during examinations and treatment, in line with their policy.
- Evidence based complementary therapies were available free to all patients at CCL on every day the centre was open. Reflexology, upper back, hand and head massage were available to help patients relax or deal with pain. Four sessions were included as part of the treatment plan. Therapists could visit patients for massage during chemotherapy treatment or this could be carried out in a dedicated treatment room. We saw from patient surveys that a few patients felt they could not always get treatment at their preferred time but that overall patients were pleased with the service. More women than men took up this service.
- Staff could refer appropriate patients for acupuncture, which could help with nausea from chemotherapy.
- Staff told female patients about a programme of free beauty workshops by the Cosmetic Foundation- Look Good Feel Better which took place monthly.
- There was information for patients about hair loss from chemotherapy and a service for wig fitting, and details of a range of suppliers. Scalp-cooling treatment (cold caps) were available to reduce hair loss. Patients were warned that using a cold cap added to the length of the visit. There were enough for all patients to use.
- Enough free car parking for all patients was available on site.
- Patients receiving chemotherapy had hot and cold drinks available throughout the day. Dietary preferences were noted and a choice of light food was offered. There were drinks available for patients attending for radiotherapy or consultations.
- A patient information group met monthly as an open forum for patients and families and had some external speakers. There were also sessions held specifically for families and friends of cancer patients.
- Chemotherapy nurses were allocated specific patients for that day to ensure continuity for the patient.

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- Doctors and nurses warned patients about common side effects and the action to take in the event of nausea, vomiting, and fatigue. At each appointment, they asked patients about any problems or side effects that had occurred since their previous cycle of treatment. Each chemotherapy patient had a red book, sometimes known as a chemotherapy diary. 'Your chemotherapy record' contained information about their diagnosis, treatment plan and treatment. They were advised to take this to any medical appointment, whether or not cancer-related.
- As mentioned in the section on well led, patient representative attendance at a CCL meeting that discussed patient pathways gave a user perspective.
- Patients requiring urgent inpatient care as a result of their cancer were admitted to the oncology unit at nearby Parkside hospital and patient notes from CCL were immediately accessible.
- Patients could bring a friend or relative to sit with them during chemotherapy treatment.
- Some staff had training to help patients living with dementia.
- There was a lift for patients using wheelchairs.
- There was no bariatric equipment at CCL.
- There were no curtains around the chemotherapy chairs, although wooden screens were available. This could limit patient dignity if they became unwell or had a problem with their treatment as the screens were cumbersome to move.

Learning from complaints and concerns

- We saw an information leaflet for patients on display in many areas 'Listening, Acting, Improving' which outlined how patients could raise any concerns, both informally and formally, as well as details on the complaints process. There was also information on the website. Patients were encouraged to give their views.
- Staff told us that as far as possible they tried to resolve any concerns raised by patients face to face. Staff recorded verbal complaints on a specific form which enabled managers to oversee these. Complaints were reviewed and discussed at the weekly Parkside/CCL senior management team meetings as issues raised need highlighting and learning sharing. If a complaint was risk assessed as high, or was sensitive or complex it would be discussed with Aspen's Group Clinical Director. Complaints involving Consultants, or relating to their practice, were discussed with the individual Consultant.

The centre had received only three complaints during 2015. All were minor and had been dealt with face to face. For example told us that catering staff now wore badges and introduced themselves following a complain from a patient about not knowing who staff were.

- An annual report of complaints was collated each year identifying themes and actions taken to improve patient experience as a result of responding to concerns. Compliments received from patients and feedback comments through the patient satisfaction survey attributable to individual staff were shared with staff.

Are medical care services well-led?

Good 

We rated this service as good for well led because:

- Staff told us managers were visible and approachable.
- Staff took ownership of issues in the units where they worked and were proud of the personalised services the centre offered. They said they felt valued by managers and by patients.
- The radiotherapy department operated an effective governance structure with clinical governance reporting arrangements quarterly. Risks were identified and acknowledged and action plans were put into place to address them. Care was evidence based and action plans were regularly reviewed.
- There were systems to ensure patients were heard and listened to.
- Staff engagement was through meetings, surveys and written and oral communications.

Vision and strategy for this service

- The CCL mission was to provide first class independent healthcare to the local community in a safe, comfortable and welcoming environment, and to improve quality and clinical outcomes. This was supported by the Aspen values which included personalised attention and partnership and teamwork. Staff understood the mission and values. The centre was considering JACIE accreditation, (JACIE is a non-profit body established for the purpose of assessment and accreditation in stem cell transplantation). The high level strategic priorities were agreed by the MAC , a committee of 17 members including the Hospital

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Director, oncologists, a palliative care consultant, the heads of nursing, physics, oncology pharmacy, radiotherapy services and a medical physician. Safety was their foremost consideration. The Centre aimed to maintain CHKS accreditation and provide the latest and best treatments for patients, including new chemotherapy treatments.

- We were told a strategy for CCL was in draft but had not yet been published.
- An objective for 2015 had been to promote closer links between Cancer Centre London and Parkside Hospital so there could be an improved seamless patient journey.
- For 2016 the aim was to increase utilisation of the new LINAC and increase usage of the new modalities such as VMAT and stereotactic radiotherapy.

Governance, risk management and quality measurement

- At a corporate level, CCL was compared to other Aspen sites through the Aspen Healthcare quality governance dashboard and an exception report was presented at appropriate governance forums, including clinical review (including any trends by Consultant) by the Medical Advisory Committee. Aspen was a founder member of PHIN, the Private Health Information Network, and staff were working with PHIN to improve the availability and comparability of outcome data across the independent healthcare sector.
- The Limited Liability Partnership has a supervisory board that determined the strategy and this group meets the Aspen Board quarterly, after the meeting of the Medical Advisory Committee (MAC).
- Governance was through the MAC which was made up of representatives of the major specialities. Members were appointed for three years and could not serve more than two successive terms. It met quarterly and provided advice on clinical issues and provided a forum for representing the views of medical practitioners and the hospital director. It did not have management or executive functions. There was a standing agenda including an annual review of one service area, a review of NICE guidelines, a policy review and a review of practising privileges.
- Between MAC meetings, Quality Governance meetings were held and used integrated dashboards to compare results. Much of the governance was jointly managed with Parkside Hospital through committees with

representation from both sites. Examples of joint committees were the resuscitation committee, infection control, drugs and therapeutics committee and the blood transfusion committee. The Health and Safety committee, the employee forum and the Acute Oncology Group were also held jointly with Parkside Hospital. CCL had its own committees for Pharmacy, Chemotherapy, Physics and Nuclear Medicine.

- CCL made clinical governance reports to the MAC and to a quarterly quality meeting at the head office. New and updated clinical guidelines were signed off by the MAC.
- An Acute Oncology Group was led by the cancer manager and involved both Parkside Hospital and CCL staff and considered the provision of the cancer services across both sites
- We saw detailed risk assessments had been carried out in each area, and mitigation and details of the date of the next assessment were recorded.
- We reviewed the CCL risk register. The highest risks related to the IT server and we saw evidence of mitigating action, including plans for a new IT system. The replacement of the second linear accelerator before it became redundant was also on the risk register. The shortage of oncology nurses was recognised as a risk, and a recruitment day was planned for the month after our inspection, as the unit preferred not to use agency staff. Pharmacy had its own risk register, with no unmitigated risks. However, we noted from minutes of a meeting that some consultants were self-prescribing or asking colleagues to prescribe for them. Although we had observed openly available prescription pads, this was not on the risk register.
- We saw a robust ISO certificated Quality Management System with an external inspection and audit schedule for the current year, to ensure safety of radiotherapy, physics and chemotherapy.

Leadership of service

- Staff told us they felt supported by the centre's management team and by management staff at Parkside hospital. Managers were all visible throughout the working week within the department. Staff told us they felt valued and respected and worked in a supportive environment. They had great confidence in managers.
- There were weekly MDT meetings to discuss complex patients and gather opinions about treatment of patients.

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- The small size of the centre (52 staff) meant that staff all knew each other which helped communication. Managers used a number of other communication channels such as email, the intranet and regular staff meetings to share information.
- Unit meetings were minuted so staff who missed a meeting could catch up with any points they had missed.

Culture within the service

- There was a culture of quality and safety. Staff were committed to their work and to providing high quality care for patients. We observed effective team working and mutual respect among staff.
- Staff we spoke with enjoyed working at CCL. They described the centre as a supportive and friendly place to work with an open culture. They said they would want their family and friends to be treated there if the need arose.
- Staff told us they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents.

Staff engagement

- An annual Staff survey was carried out across the whole Aspen group to review scope for improving working lives and areas of good practice.
- Staff sickness had been 5% over the past year. However, the staffing total of 52 meant the absence of one person was a high percentage. Staff turnover was 1.9% which was lower than in the NHS.

Public engagement

- A patient representative attended the Acute Oncology Group which discussed patient pathways and any issues in chemotherapy, radiotherapy or pharmacy, audits and incidents.

Innovation, improvement and sustainability

- The department continued to drive the implementation and evaluation of new radiotherapy techniques using the new linear accelerator, such as adaptive radiotherapy, IMRT, VMAT and stereotactic treatment.
- Heart sparing radiology had won the LaingBuisson award for innovation in technology in 2015.
- The radiotherapy technique used for controlling Dupuytren's disease had excellent results for patients.

Outstanding practice and areas for improvement

Outstanding practice

- Heart sparing radiotherapy which had won the LaingBuisson award for innovation in technology in 2015.
- A radiotherapy technique for controlling Dupuytren's disease had excellent results.
- The service was outstanding in its responsiveness to the needs of its patients.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should consider improving temperature control in the chemotherapy suite and reviewing the suitability of the overflow waiting area. We understood that refurbishment was already planned.