

Supportive Care (UK) Limited

Supportive Care (UK) Ltd Head Office

Inspection report

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

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Outstanding 

Are services well-led?

Good 

Summary of findings

Overall summary

We have not previously rated this location. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. The service received assurance through audit feedback and monthly meetings with the partners. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff identified and quickly acted upon patients at risk of deterioration. Risk assessments considered patients who were deteriorating and in the last days or hours of their life. The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service provided care and treatment based on national guidance and evidence-based practice. The service made adjustments for patients' religious, cultural and other needs. Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. Staff worked together as a team with other doctors, nurses and health care professionals to benefit patients. They supported each other to provide good care. Key services were available seven days a week to support timely patient care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served. The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. Patients could access specialist supportive and palliative care when they needed it within agreed timeframes and national targets. The service had no waiting list and patients received the right care promptly.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and a proactive approach to implementing new models of care. The service shared work locally, nationally and internationally.

However:

- The service had not formally collated patient feedback specifically to Supportive Care UK patients for the previous 12 months; however, this had been implemented following our inspection.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
End of life care	Good 	We have not previously inspected the service. We rated it as good. See the overall summary for details.



Summary of findings

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Summary of this inspection

Background to Supportive Care (UK) Ltd Head Office

Supportive Care (UK) Ltd Head Office is operated by Supportive Care (UK) Ltd and located in Cheadle, Stockport.

The service provides supportive, palliative and end of life care to patients and their carers from diagnosis onwards, including treatment related problems. Provision of care is for private and self-funding patients, over the age of 18 years.

The service offers supportive oncology care 24 hours per day, seven days a week, to patients at any point of their pathway, curative or non-curative and including survivors of cancer.

The service operates a premises-based model for patients of The Christie Private Care (TCPC) part of HCA Healthcare UK. They also provide a service level agreement at the private Alexandra Hospital in Manchester.

Patients are referred to the service from these hospital sites and are referred at any stage for problems requiring supportive care input. Referrals span across the entire range of cancer disease types, including rare and haematological cancers. The service receives referrals for patients across Greater Manchester and beyond.

The service has two clinical nurse specialists, three consultants who work under practicing privileges and a lead operational nurse who is also the registered manager. The team provides care and treatment to inpatients in addition to remote consultations. They also offer outpatient clinics throughout the week.

Activity during the reporting period April 2022 to March 2023:

- There were 200 new consultations and 559 follow up consultations.
- There were 130 patients seen by the clinical nurse specialists and 118 follow up appointments.
- There were 79 patients new to the service seen by the clinical nurse specialists.
- There were 97 inpatient contacts and 46 outpatient contacts with the clinical nurse specialists.

Supportive Care (UK) Ltd Head Office has been registered with the Care Quality Commission (CQC) since April 2019 and is registered to provide treatment of disease, disorder or injury (TDDI). The regulated activity of TDDI applies to the care and treatment provided by the clinical nurse specialists.

The service was previously registered at a different address from November 2018 to April 2019 and has been monitored through our engagement and transitional monitoring approach.

The registered manager has been in post for three years, although they were employed by the service five years prior in other roles.

We have not previously inspected Supportive Care (UK) Ltd Head Office.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 3 April 2023.

Summary of this inspection

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate

During our inspection we visited the TCPC clinic where the staff were based. We interviewed staff who were employed by the service, including the registered manager, clinical nurse specialists and consultants. We also spoke with staff employed by TCPC, visited non-clinical areas, spoke with patients and reviewed patient records.

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

Outstanding practice

We found the following outstanding practice:

- The supportive and palliative care service offered by the team was the only 24/7 service of its kind within a private hospital setting in the UK.
- The service model has been adopted by hospitals, hospices and NHS trusts to address gaps in the workforce and implement the key assurances of consultant advice. It was now a national initiative in more than 20 cancer centres.
- The service received two Health Service Journal (HSJ) awards in 2021 and 2022, one for partnership with the NHS and one for partnership with 'not for profit' organisation.
- The clinical nurse specialists were supporting the first Enhanced Supportive Care model within the private health insurance market. The private health insurance was offering a clinical nurse specialist -led consultation to every member who received a diagnosis for incurable cancer. Several other major health insurers have shown interest in developing a similar support service for their members.
- The medical director (MD) had been invited to present at two national conferences this year on the topics of workforce in supportive and palliative care and delivered a workshop on the role of MD. The CEO and MD had recently been invited to speak at the British Journal of Hospital Medicine Conference. They spoke about the challenges of delivering remote palliative and were part of an expert panel discussing the future of palliative care.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **SHOULD** take to improve:

- The service should continue to collect and collate patient feedback specifically to Supportive Care UK patients.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Good	Good	Good	 Outstanding	Good	Good
Overall	Good	Good	Good	 Outstanding	Good	Good

End of life care

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

Is the service safe?

Good 

We have not previously rated safe. We rated it as good.

Mandatory training

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

Mandatory training was delivered through e-learning with some face-to-face training modules. The service had a mandatory training policy and summary which was comprehensive and met the needs of patients and staff. Mandatory training covered key topics such as fire safety, health and safety, infection prevention and control, information governance, data protection, equality and diversity. It also included training to support patients with learning disabilities and autism.

The registered manager, nursing staff and medical staff received and kept up-to-date with their mandatory training. Nursing staff consisted of two clinical nurse specialists. Managers monitored compliance and alerted staff when they needed to update their training.

Medical staff consisted of three consultants. They completed mandatory training with their substantive NHS employer and provided annual confirmation of completion of this training in line with the practising privileges policy.

All staff had completed the appropriate level of adult life support training.

All clinical nurse specialists had completed the relevant neutropenic sepsis management training in line with the National Institute for Health and Care Excellence (NICE) clinical guideline CG151- Neutropenic Sepsis: prevention and management in people with cancer. They had completed this training within their role as a registered nurse and as they progressed into the specialist roles.

Neutropenic sepsis training was also available on the e-learning platform. All new nursing staff within an oncology setting completed foundation study days that included sepsis management. The clinical nurse specialists also educated patients and carers about neutropenia and sepsis.

End of life care

The staff we spoke with told us mandatory training was accessible and they were given enough time and support to complete their mandatory training.

Safeguarding

Staff had training on how to recognise and report abuse and they knew how to apply it.

Mandatory training included safeguarding training.

All staff had completed the appropriate level of safeguarding adults training up to level two or three and safeguarding children level two.

Medical staff completed mandatory training with their substantive NHS employer and provided annual confirmation of completion of this training in line with the practising privileges policy.

The service had a safeguarding policy which covered all aspects of potential abuse such as physical abuse and neglect. It described what actions to take. Staff we spoke with knew how to make a safeguarding referral and who the partnering safeguarding lead was if they had concerns.

Cleanliness, infection control and hygiene

The service had service level agreements in place with the partner hospital sites. The partners were responsible for monitoring infection prevention and control. The service received assurance through audit feedback and monthly meetings with the partners. Staff used equipment and control measures to protect patients, themselves and others from infection.

The service had service level agreements in place with the two hospital sites. The partners were responsible for the cleanliness of the wards and furnishings in addition to hand hygiene audits and environmental infection control audits. Results from the audits were shared and the service received further assurance through monthly meetings with the partners. The lead operational nurse met monthly with the hospital matron to discuss quality, safety, staffing and environment.

Staff could access the hospital sites infection prevention and control (IPC) policy and staff we spoke with were familiar with current infection prevention and control guidelines. The infection control link nurse worked with the partner NHS hospital's IPC team so staff had access to training, shared learning and policies.

All staff had completed mandatory IPC training. Staff told us they followed hand hygiene and bare below the elbow protocols when attending to patients and used appropriate protective clothing when caring for patients to prevent the risk of infection.

Environment and equipment

The service had service level agreements in place with the partner hospital sites. The partners were responsible for ensuring that the design, maintenance and use of facilities, premises and equipment kept people safe. This included the management of clinical waste.

The service had service level agreements in place with the two hospital sites. The partners were responsible for the environment, equipment and for the management of sharps and clinical waste. The service received assurance that the design, maintenance and use of facilities, premises and equipment kept people safe. This was through audit feedback and monthly meetings between the lead operational nurse and hospital matron.

End of life care

Assessing and responding to patient risk

Staff knew about any specific risk issues and identified and quickly acted upon patients at risk of deterioration. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. They used national early warning score systems (NEWS2) to monitor patients who were deteriorating, or at risk of deteriorating to ensure any changes to their medical condition could be promptly identified.

Clinical nurse specialists we spoke with knew about any specific risk issues such as sepsis, falls and pressure ulcers. They were able to describe what they would do if they suspected a patient had sepsis and told us they would escalate this to the nurse in charge. The outreach team from oncology were informed of any patients with suspected sepsis and there was a sepsis nurse from the partnering NHS trust. The service also had access to critical care support for 24 hour emergency cover for patients whose condition was deteriorating.

Staff told us that as a service they were also part of the oncology discipline and that 'sepsis six' was implemented. This describes the six processes which, when done within an hour, have been shown to increase survival. They told us that sepsis management posters were displayed on the ward and sepsis alerts were on electronic results within the patient web based portal.

The clinical nurse specialists told us they had identified patient risk during a phone call and directed the patient to call the 24 hour hotline at the partnering NHS trust. They also informed the patients consultant.

The service triaged patients on their inpatient list and graded them into categories of red, amber and green (RAG) dependent on their treatment needs. The red category was high priority and included any new patient who had not yet been reviewed by their service. This could be a face to face review or over the phone. Other indicators included patients who were not responding to multiple medication regimes, physical symptoms changing due to clinical condition and complex psychological symptoms and family dynamics. Amber category was moderate priority for those patients with minor medication regimes and who had better symptom control with moderate complexities. Green category was low priority for patients who had non-complex physical and psychological symptoms.

Each category had a plan appropriate to the RAG rating. High priority documented plans covered the next 24-48 hours, moderate priority plans covered the next 2-4 days and low priority covered the next 5-7 days. Once complexity was addressed, patients moved down the RAG rating.

Risk assessments were the responsibility of staff at the partner hospital sites. These included risk assessment for falls, pressure ulcers, nutritional needs and venous thromboembolism (VTE). The service had access to the risk assessments on the patient web based portal.

Staff shared key information to keep patients safe when handing over their care to others. This was done through the daily multidisciplinary team meetings. Shift changes and handovers included all necessary key information to keep patients safe.

Clinical nurse specialists and consultants discussed patient risks in the daily multidisciplinary team (MDT) meetings with staff from the partner hospital site. These took place in the morning and afternoon. During our inspection we observed the afternoon multidisciplinary team meeting with a range of professionals. The meeting included a consultant from the

End of life care

service, resident medical officers (RMO's), discharge facilitator, pharmacist, matron, physiotherapist, nurse in charge, ward manager and lead dietician. The MDT meeting was very comprehensive, and staff spoke about individual patient risk in a very detailed manner. Patients with increased needs were identified and discussed such as mouth care, changes to medication, poor oral intake, risks pre and post operation, sepsis and who required one to one care.

The MDT meetings also discussed patients identified as being in the last hours or days of life. Patients had a regular review recorded on the patient web portal and moved to an end of life care plan. Staff told us that the RMO generated the care plan and the clinical nurse specialists completed the full assessment for end of life. They told us the ongoing individual care plan was reviewed regularly with ongoing assessments. They liaised with the patient's consultant and had advanced care planning discussions at length during meetings over several days. Medication, oral intake, bowel function, catheter care, mouth care, pain, nausea and agitation were all taken into account.

Staffing

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

The service had enough nursing and medical staff to keep patients safe. The service comprised of 2 clinical nurse specialists, 3 consultants who worked under practicing privileges and a lead operational nurse who was also the registered manager. During our inspection we visited TCPC clinic where the staff were based. The service had 6 out of 14 inpatients under their care at TCPC and this fluctuated over time. The consultants had 14 new consultations and 86 follow up consultations throughout March 2023, the month prior to our inspection.

The service had a monthly rota for clinical nurse specialists and consultants' which was planned a month ahead. It showed their schedules and contact numbers. Weekdays were covered by both consultants and clinical nurse specialists. Weekends, overnight and bank holidays were covered by consultants only. This meant the contracted hospital sites had access to a consultant 24 hours per day, seven days a week, 365 days a year, remotely and face to face if deemed necessary.

We looked at rota's for March and April 2023. The actual number of nursing and medical staff matched the planned numbers.

The service had low vacancy and low turnover rates. At the time of inspection there were no vacancies and existing staff had been there for many years and had stayed since the service was established.

The service ensured adequate consultant and clinical nurse specialists staffing through their workforce planning. They reviewed their service level agreements with the hospital sites every 3 years with their partners to plan the workforce. The service had increased its consultant and clinical nurse specialist establishment over the last 3 years as a result of this.

The service had a business continuity plan which outlined that any short-term unscheduled absence of clinical nurse specialists would be cross covered by a consultant. If a consultant was absent then the registered manager contacted other consultants to arrange cross cover. The business continuity plan covered short term, medium and long-term gaps in staffing.

The service had clinical nurse specialist contracted bank staff (on zero hour contracts) to use if staff were absent for over a week or month. There were fully recruited and had completed a full induction. The rate of bank staff was low and they did not use agency staff.

End of life care

Records

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

Staff kept detailed records of patients' care and treatment. Records were comprehensive, clear, up-to-date and stored securely. All staff could access the records easily on the patient web based portal.

Staff informed patients GP's when they were identified as needing end of life care. The patient web based portal sent an automatic notification to the GP's. Staff could request a GP visit that day or the following day when the patient was identified as being in the last hours or days of life.

Discharges were also communicated to GP's through the patient web based portal and the GP's could access patient care summaries through the system.

Medication changes were recorded on the patient web portal and communicated promptly to the GP. Both GP's and community specialist nurses had access to the portal to view patient records. Staff also sent correspondence to care home staff, hospice staff or domiciliary staff to share discharge summaries and medication changes.

The service used an alternative to DNAR (do not attempt resuscitation) forms called AaND (allow a natural death). We observed a patient record with a documented AaND form that had discussions with the patient clearly recorded. These were signed appropriately by a senior clinician such as a consultant or RMO.

During our inspection we looked at some patient records and saw comprehensive admission assessments and daily assessment of symptoms and symptom management. There was also detailed documentation of communication with patients and families.

Medicines

The service had service level agreements in place with the partner hospital sites. The partners were responsible for ensuring that systems and processes were in place to safely prescribe, administer, record and store medicines.

The service had service level agreements in place with the 2 hospital sites. The partners were responsible for ensuring that systems and processes were in place for staff to prescribe and administer medicines safely. This included medicine audits such as antimicrobial stewardship. Results from medicine audits were shared and the service received further assurance through monthly meetings with the hospital matron.

The clinical nurse specialists did not prescribe medicines, but they reviewed each patient's medicines regularly and discussed this at daily MDT meetings. They also provided advice to patients and carers about their medicines. Patients we spoke with told us that they had received regular advice and guidance regarding their medicines at follow up appointments and telephone calls.

The consultants worked under practicing privileges and were available to prescribe medicines 24 hours a day. This meant patients could receive appropriate management of their symptoms when required.

Staff told us that the onsite pharmacist dealt with the discharge medicines and as a team they shared information verbally with patients. The onsite pharmacist was employed by the partnering hospital site. Patients were also given a discharge summary with a list of their medicines to take home along with booklets and leaflets.

End of life care

The clinical nurse specialists told us they explained the prescription of any unusual medicines to the patients' GP to make it easier to access in the community. Staff supported patients to receive monthly injections for effective medicines to improve quality of life.

Staff recorded information on medicines in the patient records on the web portal. However, medication charts were in paper form. Staff told us electronic prescribing would be implemented soon.

Staff followed processes to ensure appropriate anticipatory prescribing. Clinical nurse specialists told they worked closely with the complex discharge team who prescribed appropriate anticipatory medicines. The clinical nurse specialist would adjust the dosages as required. There was correct authorisation in place to enable the administration of anticipatory medicines. The district nurse completed the authorisation letter with an explanation of anticipatory medicines for the patient to take home. It included the dosage and usage of the medicine. The clinical nurse specialists told us they informed the patients GP and requested a GP home visit in addition to referrals to specialist nurses or palliative care teams.

Clinical nurse specialists told us that syringe pumps were prescribed and monitored correctly with the duration of infusion clearly indicated. They told us they used specific syringe driver forms and that whatever was prescribed was clearly recorded on the form and checked every four hours. There was a syringe driver chart for nurses to regularly record information such as a battery change, issues with infusion and if so, what was done to rectify it. They gave an example of making prompt changes to the syringe driver a few times a day to meet the need of the patient.

Incidents

The service had service level agreements in place with the partner hospital sites. The partners were responsible for ensuring the service managed patient safety incidents well.

The service had its own incident log for any incidents that did not fall under the partners responsibility. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service had service level agreements in place with the two hospital sites. The partners were responsible for reporting incidents that occurred onsite. Incidents reported by the partnering hospital sites were shared in weekly governance meetings. The service received further assurance through monthly meetings with the hospital matron to discuss quality and safety.

The service had its own incident log for any incidents that did not fall under the partners responsibility. In the previous 12 months the service had reported 1 incident that involved the on-call rota and staff described the learning from this. Staff told us this was addressed immediately to ensure the patient was assessed in a timely manner. There was no harm caused to the patient on this occasion which meant it did not require a root cause analysis investigation.

Staff met to discuss the feedback and look at improvements to patient care. The incident was discussed in the next quality assurance meeting and a letter was written to the complainant to apologise and shared what learning and changes had been put in place. It was then reported to the board and as a result the service changed their on-call arrangement.

Staff told us they could access the hospital sites incident reporting policy.

End of life care

Staff knew what incidents to report and told us they would report incidents themselves on the partner hospital electronic reporting system. Alternatively, they would escalate information to hospital staff to report and provide information towards any incident being investigated.

Learning from incidents was shared to staff directly through the hospital matron on site, through weekly governance meetings, monthly meetings with the matron and medical advisory committee. Staff also received quarterly learning from experience reports that were shared by the partnering hospital site.

The service had its own duty of candour policy in place and staff were able to tell us what their responsibility was when something had gone wrong. Staff we spoke with gave examples of being honest and truthful with patients and families. The duty of candour is a regulatory duty that relates to openness and transparency with patients if their treatment causes or has the potential to cause harm or distress. The registered manager told us that there is a duty of candour section in their incident reporting process.

Is the service effective?

Good 

We have not previously rated effective. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

The service had service level agreements in place with the partner hospital sites. The partners were responsible for ensuring there were up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff we spoke with knew how to access the policies. The service reviewed their service level agreements with the hospital sites every three years with their partners.

The registered manager told us that the partner hospital site had an audit schedule and shared monthly observational audits, patient experience feedback and learning from mortality reviews. The service had access to this information and data through shared governance with their partners.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Through assessments and MDT meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

The service provided care and treatment that followed National Institute for Health and Care Excellence (NICE) guidelines and met NICE quality standards. It was evident from the care records we reviewed, the advanced care planning and the MDT meeting we observed that NICE guidance and quality standards were being followed. This included 'care of dying adults in the last days of life' (NG31), 'care of dying adults in the last days of life' (QS144) and 'improving supportive and palliative care for adults with cancer' (CSG4).

The service used a systematic approach to identify patients who were likely to be approaching the end of their life. New admissions with end of life care needs were highlighted at the daily MDT meetings. Patients discussed advanced care

End of life care

planning with the clinical specialists and care was coordinated between allied health professionals across different services. Patients and their carers also had access to support 24 hours a day, 7 days a week. The service made relevant referrals and signposted carers to support services in the community. This model of working followed all the quality statements for NICE 'end of life care for adults' (QS13).

The service provided end of life care that achieved the priorities for care of the dying person set out by The Leadership Alliance for the Care of Dying People. This was set up to lead and provide a focus for improving the care for people, their families and carers. The priorities were embedded in patient assessment forms such as the advanced care planning documentation, care in the last days of life management and ongoing assessment forms and the recognition of dying form. These forms also enabled the partner hospital site to monitor how personalised end of life care was.

The service evidenced clearly how their model of care implemented all of the 'ambitions for palliative and end of life care' national framework (2021-2026). Leaders recognised that there were gaps within private healthcare in regard to accessing care. The service helped bridge the gaps and ensured partnerships outside of private healthcare. For example, through collaboration with GP's and community services.

The service provided care across the whole cancer pathway, this included treatment to minimise the side effects of radiotherapy and chemotherapy. One of the consultants was president of the UK association of supportive care in cancer (UKASCC) and had extensive knowledge on prevention and management of side effects. Performance was monitored and audited by the partnering hospital site.

The service did not conduct their own audits. However, the clinical nurse specialists were regularly involved in the partnering audit schedule and action plans at the hospital site. Leaders told us that the RAG inpatient triage system was scheduled to be audited. They were waiting for the NHS clinical outcomes to be added electronically to the patient web portal to allow for continuous reporting.

Nutrition and hydration

Staff monitored nutrition and hydration regularly to meet the needs of patients and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Patients we spoke with told us they had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Staff had access to and worked closely with dieticians at the partner hospital site. Staff routinely discussed patients' dietary needs, how to manage sickness and loss of appetite. One patient told us that they had received support with diet supplements and free samples to help them gain weight. Another patient told us that staff explained clearly what they could eat and why they were having reduced food intake. Patients were given advice about hydration and there was water available in the department.

It was evident from the records and assessment forms we looked at that staff monitored nutrition and hydration regularly to meet the needs of patients and improve their health. The clinical nurse specialists and consultants worked closely with appropriate hospital professionals at the daily MDT meetings. During our inspection we observed staff discuss the nutrition and hydration needs of patients. This included special feeding and hydration techniques where appropriate.

It was the responsibility of partnering nursing staff to complete patients' fluid and nutrition charts and to monitor patients at risk of malnutrition. Audits related to fluid and nutrition were completed by the partner hospital site and shared at monthly meetings.

End of life care

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using recognised tools and gave pain relief in line with individual needs and best practice. The service prescribed opioid medicines in line with the Faculty of Pain Medicine of the Royal College of Anaesthetists guidance.

Staff used pain assessments including the numerical pain rating scale (NPRS) and visual analogue scale (VAS) which was in line with the British Pain Society (BPS) and the Greater Manchester Palliative Care Pain and Symptom Control guidance.

Staff told us they also used pictures for patients to communicate levels of pain when they could not communicate this verbally.

Staff assessed and monitored pain in line with the core standards for pain management in the UK (2015). This was evident from the care records we reviewed and advanced care planning documentation. The clinical nurse specialists worked closely with appropriate hospital professionals at the daily MDT meetings, which facilitated dialogue regarding the best pain management options for patients.

Patients with cancer-related pain received timely pain assessments and the cause, intensity and impact of the pain was discussed at the daily MDT meetings. Patients and carers received adequate information on the use of pain relief in the form of information guides. These were available at the hospital information centre and the pharmacy.

Patients received pain relief soon after requesting it. Clinical nurse specialists had completed competency training to support ward nurses in the administration of controlled drugs. This meant that delays were minimised, and patients received the medication in a timelier manner.

Access to pain relief was available 24 hours a day and discussions we had with ten patients informed us that pain was assessed regularly and managed effectively. Patients spoke positively about how staff addressed their level of pain. They told us it was a main focus and staff would change the type and dose of pain relief to meet their needs. One patient told us that they noticed a significant difference in reduced pain after being referred to the service.

The clinical nurse specialists and consultants asked patients about pain at every appointment and follow up. If patients required pain relief, they contacted the consultant or the resident medical office for appropriate pain relief. They could refer patients to the specialist pain team in the NHS partner organisation if necessary. A clinician from the service would see a patient on the same day of a referral and outpatients were contacted by telephone remotely. The next available face to face appointment would be scheduled that week.

Anticipatory medications were prescribed for patients identified as requiring end of life care. This was audited within the monthly observational audit. Audits were the responsibility of the partnering hospital site and results were shared with staff onsite at team meetings.

Patient outcomes

Staff worked with partners to monitor the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

End of life care

The regulated activity of TDDI applied to the care and treatment provided by the clinical nurse specialists. The service had recognised gaps within private healthcare in regard to patients accessing specialist palliative and supportive care. The service level agreement with the partner hospital outlined that the service would provide a consultant led palliative care service, supported by the clinical nurse specialists. The aim of the service was to fill this gap in provision and meet the supportive, palliative and end of life care needs of patients and their carers from diagnosis onwards, including treatment related problems.

Data showed that the service achieved good outcomes for patients. At the time of inspection, 100% of all new patients were seen within 24 hours of first referral by a consultant. Similarly, 100% of patients who needed urgent outpatient reviews were seen by a consultant or clinical nurse specialist within one week of initial referral.

The lead operational nurse provided an annual report to their partners with an overview of the service activity and patient feedback. Clinical nurse specialist and consultant activity from April 2022 to March 2023 showed positive outcomes for patients. Most interventions were at an advanced level with patients and their relatives being seen on a frequent basis. The activity had remained constant compared to the previous year with a 20% increase in telephone consultations to patients.

Staff worked with partners to monitor the effectiveness of care and treatment. The registered manager told us that the partner hospital site had an audit schedule for relevant national and local clinical audits. Results from audits, patient experience feedback and learning from mortality reviews were shared with staff at monthly meetings. The service had access to this information and data through shared governance with their partners.

Mortality reviews were undertaken by the partner hospital site to share good practice and identify opportunities for learning.

The service routinely collected and monitored information about the outcomes of peoples care and treatment. All patients had an outcome which was actioned and recorded on the patient web portal. This included a patient being discharged, having a follow up appointment or cancer treatment and planning. All inpatients had discharge plans that were shared with their GP and other relevant healthcare professionals in the community.

Consultants attended monthly medical advisory committee (MAC) meetings where the partners discussed issues, strategy, governance and reviewed deaths. They also looked at the quality of end of life care provided by their team and whether it was delivered in a timely way. Consultants told us that it was a useful process and generally showed positive results. They were assured that their team were always involved with patients who are at the end of life.

The service received provider reports for their partner hospital site which benchmarked their performance against the other provider hospitals. Leaders told us the benchmarking showed favourable and positive performance for their service.

The service was looking at other ways to capture the effectiveness of patient outcomes. They planned to audit the RAG inpatient triage system and record integrated palliative care outcome scale (IPOS) scores into the patient web based portal.

Competent staff

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

End of life care

Staff were highly experienced, qualified and had the right skills and knowledge to meet the needs of patients. The clinical nurse specialists provided symptom control and advanced care planning for patients. They worked in close partnership with other professionals within the partner hospital site, undertook joint assessments, attended case discussions and clinical team meetings.

Clinical nurse specialists also delivered end of life care training to staff at partner hospital sites.

Managers gave all new staff a full induction tailored to their role before they started work. Staff then had full access to additional healthcare training courses online.

Consultants worked under practicing privileges and were required to submit evidence of their clinical appraisal annually from their main employer which was usually an NHS trust. This was reviewed as part of the practicing privileges process and recorded on a database for each consultant.

Managers supported clinical nurse specialists to develop through yearly, constructive personal development reviews. Clinical nurse specialists had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. They had attended specific training events during the previous 12 months such as a dementia and cancer study day, Greater Manchester cancer conference, virtual educational events and a Royal College of Nursing accredited webinar. One clinical nurse specialist had completed an advance care planning facilitator course and had subsequently delivered the training to other staff members.

Consultants participated in quarterly consultant forums. The forums provided consultant led continuous personal development activities such as ketamine use and seizure management.

Clinical nurse specialists and consultants were skilled and confident when communicating with patients and families at the end of life. They had completed advanced communication skills training which included both verbal and nonverbal communication methods. In addition, some staff delivered training for advanced communication to other health care professionals.

Leaders told us that the governance team identified potential training needs by looking closely at themes from patients' symptoms and how these were managed.

The service recognised that caring for patients at the end of life can be highly emotive. Staff wellbeing was supported in a variety of ways, such as accessing the partner NHS trusts employee assistance programme and the promotion of external support services.

Multidisciplinary working

Staff were dedicated to collaborative working with other doctors, nurses and health care professionals to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. During our inspection we observed the afternoon MDT meeting with a range of professionals who discussed patients' complex needs. Clinical nurse specialists and consultants attended the meetings with partnering hospital staff such as RMO's, discharge facilitator, pharmacist, matron, physiotherapist, nurse in charge, ward manager and lead dietician. The MDT meeting was holistic, comprehensive, patient focused and well-coordinated. We saw evidence of documented plans for ongoing treatment and symptom management.

End of life care

The clinical nurse specialists also worked alongside consultants on the inpatient ward and in outpatient clinics.

Staff told us they had good relationships with consultants, doctors, nurses and other healthcare professionals at the partner hospital site. Similarly, hospital staff told us the clinical specialists and consultants were approachable and responsive. They worked well together as an integrated team and valued their input.

Staff worked closely with and regularly updated the lead consultant who had overall responsibility for individual patient's care.

Staff worked across health care disciplines and with other agencies when required to care for patients. They had good working relationships with community health care professionals when transferring care and shared relevant information such as discharge summaries and care plans.

Staff escalated patients to the RMO's for mental health assessments when they showed signs of mental ill health and signposted patients to psychological support services.

Testimonials from partnering consultants at the hospital site were extremely positive. Consultants described how staff provided a critical and collaborative approach to patient management. They viewed the service as an integral part of the medical oncology team and supported patients from diagnosis through to the end of the patients' lives. Another consultant felt that the collaborative working enabled them, as an oncologist, to provide holistic care to patients. They were confident that input from clinical nurse specialists and consultants ensured timely discharge and handover to community services.

Seven-day services

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

The service provided palliative and supportive oncology care 24 hours per day, seven days a week. Weekdays were covered by both consultants and clinical nurse specialists and weekends were covered by consultants only.

The service provided care and treatment to inpatients based at the hospital site. The inpatient ward was open and staffed 24 hours a day, seven days a week.

The service provided outpatient clinics during the week with both clinical nurse specialists and consultants.

The service also offered remote consultations for patients and staff based at the partnering hospital sites. This meant that patients had access to a consultant 24 hours per day, seven days a week to support timely care.

Health promotion

Staff gave patients practical support to help them live well in their last days of life.

Patients could access relevant information promoting healthy lifestyles and support through staff sharing practical support and leaflets on the ward. Patients could also access relevant health information from the hospital's onsite information centre.

Staff worked collaboratively with hospital staff to assess and monitor each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

End of life care

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The service used an alternative to DNAR (do not attempt resuscitation) forms called AaND (allow a natural death). Records we observed showed that decisions were made appropriately by a senior clinician and in line with national guidance. This was audited by the partnering hospital site and results shared at monthly meetings.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They told us they escalated patients who needed mental capacity and mental health assessments to RMO's.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). They knew how to escalate a patient if they required a DoLS application. They could describe the safety measures put in place to support them and attended best interests' meetings for patients when required.

The clinical nurse specialists had received training in the Mental Capacity Act (MCA) 2005 through their mandatory training. Consultants completed this training with their substantive NHS employer and provided annual confirmation of this in line with the practising privileges policy.

Staff followed national guidelines when caring for patients who lacked capacity to make an informed decision; they understood that nursing and clinical decisions made were in the patient's best interest in line with the MCA.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed that staff had clearly recorded consent in patients' records.

Is the service caring?

We have not previously rated caring. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. They took time to interact with patients and those close to them in a respectful and considerate way. This was evident in the feedback from patients we spoke with and also from thank you cards, emails and messages to staff. We also observed patient records that showed advance care planning and bereavement support took place in the 'quiet room'.

Patients told us that staff had a very friendly manner and used conversations effectively to build a rapport that helped them understand needs beyond clinical requirements. Patients told us they appreciated that staff had discussions with them that explored their life beyond their cancer diagnosis.

End of life care

Patients said staff treated them well and with kindness. Patient feedback was continually positive. Comments from patients we spoke with included, “staff were caring and lovely, I could not fault them”, “they made me feel at ease and nothing was too much trouble” and “staff would phone me to ask how I was and made me feel welcome if I ever phoned them for advice”. Another patient described the care as “outstanding, they really do look after all your needs”.

During our inspection we observed an MDT meeting which evidenced many examples of a caring and compassionate approach. Staff discussed how they had acknowledged the patients fears during a discharge discussion and given them extra time to make decisions. Staff had given patients one to one support when required.

Staff followed policy to keep patient care and treatment confidential. All discussions with patients took place in the quiet room or consulting rooms to ensure privacy.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff had access to information on dealing with patients with dementia and had recently attended a dementia and cancer study day.

Staff provided compassionate support for patients and relatives to help them come to terms with the development of their illness, including end of life. They understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, staff asked patients in their advance care plan how they could adapt care to meet such needs. One care plan we looked at showed that a patient had accessed support in all areas of their life from financial affairs to accessing a chaplain and a religious ceremony. Staff noted information regarding social and other circumstances in records to ensure care was individualised, such as adapting the package of care to accommodate the individual’s home situation.

The MDT meeting we observed frequently discussed patients personal needs such as needing more time to process a prognosis before discussing a hospice transfer and how religious support had helped a patient.

Patients said they felt staff delivered personalised care. They said, “the main focus was me” “they were always trying new ways to help my pain and symptoms” and “staff would change appointment times to suit me”.

Clinical nurse specialists looked for innovative ways to meet patients’ individual needs. This was validated by partnering hospital staff who described their ideas as forward thinking. For example, while memory boxes would be common in such a service, staff went above and beyond to create a mould of a fathers’ hand to create memories for their children. When patients could not leave the hospital, they brought special events to them such as creating a Santa’s grotto in their room and bringing family to their room for a football presentation.

During the pandemic, clinical nurse specialists had visited families to offer emotional and bereavement support. They also used the home visits to provide updates to families who were unable to visit onsite.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

End of life care

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed this during our inspection and patients we spoke with told us they had been offered emotional and psychological support. One patient said, “emotional support was very good” Another patient told us, “I didn’t need emotional support, but staff always asked me did I want to speak to someone”. One patient had attended sessions with a psychologist and said they found it really beneficial and was glad for the referral.

Staff were trained and trained others on communicating bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We observed a thank you letter from a family member who had accessed bereavement counselling after being signposted by staff. They spoke very positively about the process and the benefits it had brought to their life.

Patients noted the efforts of staff to provide a safe and calm space. Patient feedback showed that many families showed gratitude for being able to use the quiet room and sleep with their loved ones overnight.

The partner hospital site shared patient feedback with the service especially when it related to their staff. One patient said, “staff were truly professional with a really caring demeanour”. Another patient noted, “staff have been by our side during a number of tough times, their dedication and passion is apparent” and “staff were charming, lovely and caring, full of information and advice. They always go the extra mile”.

A common theme of patient feedback was that staff showed a genuine interest in not only their care but them as a person outside of their diagnosis. A number of patients told us that “they never felt rushed” and “nothing was too much trouble”.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with told us that staff communicated information in a way that was easy to understand. They used communication aids where necessary such as pictograms or drew pictures to convey information.

The partnering hospital sites gave patients and their families the opportunity to give feedback on the service and their treatment. Feedback from the patient surveys was shared with the service.

Staff supported patients to make advanced decisions about their care through comprehensive advance care planning. We looked at a care plan that clearly documented both patient and family preferences regarding place of care, place of death, making memories, practical support, their current situation and expectations.

Staff supported patients to make informed decisions about their care. Patient booklets contained clear, jargon free information on medicines, treatments and side effects.

Staff referred patients to hospices appropriately and held discussions with patients and families regarding this option. They clearly documented the outcomes of such discussions.

End of life care

All patients we spoke with gave positive feedback about the service. We saw examples of patients and families sending thank you cards, emails and letters for being 'looked after so well'.

The partner hospital site was responsible for conducting patient surveys and they shared results with the service through site meetings. We observed two examples that were related directly to the service and the patients were very positive about the care and treatment they received.

The service had its own specific patient satisfaction feedback form. Questions were related to the care received, were patients' needs met, did they feel listened to and treated with dignity and respect. The form could be completed by a patient or their family member/friend.

However, the service had not formally collated patient feedback through these forms for the previous 12 months. The lead operational nurse told us that they had made at least monthly visits to patients and partner hospital staff to gather feedback on the service and care. They told us that feedback had always been very good with no concerns noted or actions identified.

Following our inspection, the service carried out a patient experience survey in April 2023 with 22 patients. There was a response rate of 81% and 100% of patients said their overall experience of the service was good or very good. In addition, 100% of patients said they would strongly recommend the service to others.

Is the service responsive?

Outstanding



We have not previously rated responsive. We rated it as outstanding.

Service delivery to meet the needs of local people

The service planned and provided an innovative model of care to meet the needs of local people and the communities served. The service had recognised gaps within private healthcare in regard to patients accessing specialist palliative and supportive care. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The service offered patients direct access to the clinical team 24 hours a day. The inpatient service was available seven days a week, outpatient clinics were available twice a week and remote consultations were also available 24 hours a day.

The service offered telephone and virtual appointments to support patients and families that were not local, elderly or too frail to travel.

The service, unlike many other supportive and palliative care teams, also saw patients who were on a curative treatment pathway. This included survivors of cancer.

End of life care

The service worked jointly with other partners in the system to plan for end of life needs for all patients. Staff worked collaboratively on the ward with all medical staff and allied health professionals based at the partnering hospital site. The joint working was also achieved through daily MDT's and linking in with chaplaincy, psycho-oncology, bereavement and complimentary therapy teams. Externally the service also worked with NHS colleagues, consultants in palliative care, GP's, hospices, care homes and community teams.

Facilities and premises were appropriate for the services being delivered. The hospital was on one level and accessible by lifts. There were sufficient clinic and consulting rooms for both inpatients and outpatients. There was also a bereavement suite for families and a quiet room for staff to have sensitive discussions. There were central resources provided at the partner hospital sites for managing spiritual and cultural needs.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff had access to specialist lead nurses based at the partner NHS hospital. Staff also communicated with the mortuary and bereavement team for any specialist needs of patients.

Managers monitored and took action to minimise missed appointments. If patients did not attend appointments they were contacted by staff by telephone to rebook, usually within a week.

Meeting people's individual needs

The service was inclusive. Individual needs and preferences were central to the delivery of care and treatment. Staff made reasonable adjustments and took a proactive approach to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Additional needs were discussed within initial assessments and patients identified with mental health needs were given further assessments by an RMO.

Staff supported patients living with dementia and learning disabilities by using 'this is me' documents and patient passports. Staff had recently completed training to support patients with learning disabilities and autism. They had also attended a dementia and cancer study day. Patients could have unrestricted visiting hours if required and family members could sleep over night with their loved ones.

The service took account of patients' individual needs in detail during the daily MDT meetings and patient assessments. We observed this during the MDT meeting and records we looked at. They included spirituality, family life and personal and psychological needs. We also saw evidence of discussions with family regarding preferred place of care and death and best interest decisions for patients without capacity.

The service could translate any information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff could access alerts for patients with additional needs so they could meet the accessible

End of life care

information standard (AIS). The standard sets out a specific approach to identifying, recording, flagging, sharing and meeting the communication and support needs of patients, carers and families with a disability, impairment or sensory loss. Patients could request information in large text, sign language or easy read text. Staff used communication aids such as pictures and supported patients to use drawings to describe their feelings.

Patients were given a choice of food and drink to meet their cultural and religious preferences. One patient we spoke with told us how catering staff had gone above and beyond to make adjustments for their dietary preferences.

Staff made adjustments so that patients' families could access bereavement support by offering chaplaincy input, home visits, phone calls and signposted them to external bereavement services in the community. Staff told us they also signposted patients and families to community cancer support services and requested a GP visit for family members when they were concerned for their wellbeing. Staff also supported children and their families through local counselling referrals, children's resources and referrals to a children's bereavement charity.

Staff made reasonable adjustments for patients with capacity who refused treatment and wanted to discharge themselves. Staff we spoke with told us that they would escalate the situation appropriately to the RMO and lead oncologist. They would facilitate patients to go home as safely as possible after a risk assessment. Staff told us they supported the patient's choice to go home and had an 'open door' policy for them to return at any time.

Access and flow

Patients could access specialist supportive and palliative care when they needed it within agreed timeframes and national targets. The service had no waiting list and patients received the right care promptly, in a way and at a time that suited them.

Patients could access specialist supportive and palliative care 24 hours a day, seven days a week. They could be referred to the service at any point across whole cancer pathway including early referrals for patients with incurable disease. Referrals for both inpatient and outpatient services were usually made directly by the patients lead consultant or specialist nursing team. The service provided twice weekly pain and symptom control consultant led clinics.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. There was no waiting list and all inpatients were triaged within 24 hours of being referred to the service. All outpatients were seen within seven days of being referred.

Patients and families who did not reside near the hospital could receive specialist supportive and palliative care remotely through video consultations at telephone clinics. Staff told us this had increased the frequency of interaction and had enabled family members and loved ones to be involved in difficult discussions surrounding treatment options and advanced care planning.

Managers worked to keep the number of cancelled appointments to a minimum. There had been no cancelled appointments over the previous 12 months.

Managers and staff started planning each patient's discharge as early as possible and made sure patients did not stay longer than they needed to. Approaching discharges and admissions were discussed at daily MDT meetings which included follow up measures. Staff told us they would discharge patients with complex needs on a weekday to maximise community support and transportation. They would encourage patients over the weekend to wait till Monday for discharge and give them an outpatient clinic appointment that same week.

End of life care

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff planned in advance the follow up appointments for patients who had been discharged from the hospital into the community. Patients that were discharged could access support 24 hours a day, seven days a week in a number of ways. This included phone numbers for the staff and access to the hotline at the partnering NHS trust. At the time of inspection, the partnering hospital site had referred 40% of their patients to the service. Leaders told us that 100% of patients referred were seen by their palliative and supportive care staff within 24 hours. This was a mandatory target within their service level agreement.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. They had access to patient leaflets containing sufficient details on how to make a complaint without the need to ask. The website also provided this information and gave patients various options to complain such as email, electronic form, phone or letter.

Staff understood the policy on complaints and knew how to handle them. The service had its own comprehensive complaints policy that provided information on who was responsible for dealing with complaints, actions to be taken, investigation process, final response and a detailed flowchart.

The chief executive officer (CEO) was responsible for ensuring complaints were managed in line with regulations and that lessons learned were fully implemented. The lead operational nurse was responsible for managing complaints and completing the investigations. Managers told us that they would use peer group support during a root cause analysis (RCA) to investigate any complaints raised.

Patients accessed information about how to make a complaint via the partner sites complaint information guide. This informed patients that they could raise their concerns with the Independent Sector Complaints Adjudication Service (ISCAS) if they were not happy with the response they received from the service. This meant that patients could access an independent external judgement if they wanted to.

At the time of inspection, the service also had a separate complaints policy and patient leaflet that referenced the Parliamentary and Health Service Ombudsman (PHSO) for any NHS patients. However, it did not reference ISCAS for private paying patients. Following our inspection, the service reviewed the policy and leaflet and added in information and contact details for ISCAS.

Managers investigated complaints and identified themes. The service had received no complaints from patients over the previous 12 months. However, a stakeholder had complained about an issue involving miscommunication. This was fully investigated, raised as an incident, an action plan was implemented and reported to the quality assurance committee. The service implemented the necessary changes as a result of the complaint.

Staff knew how to acknowledge complaints and complainants received feedback from managers after the investigation into their complaint. We saw evidence that the complainant received a letter of apology and outlined what learning was used to improve the service.

Managers also shared feedback from complaints with staff and they could give examples of how they used patient feedback to improve daily practice.

End of life care

Is the service well-led?

Good 

We have not previously rated well led. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders at the service had the right skills and abilities to run the service. There was a clear management and leadership structure with defined lines of reporting and accountability. Directors for the service included the Chief Executive Officer (CEO), the medical director (MD), the founder director, the lead operational nurse, the finance director and clinical director (CD). There was also one non-executive director who attended the monthly board meetings and played an active role in other meetings.

The CEO, MD, CD and lead operational nurse were members of the quality assurance committee (QAC). The QAC met weekly and provided a monthly board assurance report. The committee had a terms of reference and reported to the board of directors on the development, improvement and monitoring of quality. This included clinical effectiveness, patient safety and patient experience. The committee also provided assurance on the systems and processes in relation to quality of care to achieve organisational objectives.

The lead operational nurse had been employed for over 3 years and was also the registered manager for the service. They reported weekly to the CEO, attended the weekly QAC meetings and reported monthly into the board meetings. The lead operational nurse was responsible for the board assurance framework and the risk register.

The CEO had worked at the service for 6 years and reported to the board of directors monthly. Board members had end of life care responsibilities and were active and visible to staff. The MD and founder director were consultants in palliative medicine at the partnering hospital site. The MD had worked at the service for 5 years and reported to the board of directors through the CEO.

The founder director had been employed for 9 years and reported to the MD and into the board of directors at the monthly meetings. In their role as consultant at the partnering hospital site, the clinical nurse specialists reported to them and the lead operational nurse.

Staff we spoke with told us managers and leaders, were visible, approachable, and supportive.

The service had effective systems in place to monitor compliance with the Fit and Proper Person Requirement (FPPR) Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that staff are fit and proper to carry out their roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and goals were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

End of life care

The service had a vision “to be a leading provider of independent supportive and palliative care. To work in partnership with service users and provide an innovative approach to specialist medical care in cancer and non-cancer illnesses”.

The service had recently reviewed and updated its mission statement. The mission was to “provide patients and healthcare partners with rapid access to consultant-led expertise in supportive and palliative care.’

The service had identified 10 aligned service goals that included:

- Involving service users in decisions regarding their treatment.
- To be an active and responsible member in our local health community ensuring our practice and services to our users are commissioned and provided in a way most likely to meet their needs.
- To show our users courtesy and respect at all times irrespective of ethnic origin, religious belief, personal attributes or the nature of the health problem.
- To provide the best possible quality service for our users within a confidential and safe environment through effective collaboration and teamwork.

The service held annual ‘strategy days’ with directors to review the mission statement, review service level agreements and develop ideas for the future. The most recent developments included engagement with consultants, international opportunities and to explore new IT operational systems.

Staff we spoke with were aware of the vision and goals. They expressed these when talking about their roles and responsibilities.

The vision and goals were shared through the board of directors, annual general meeting and into weekly meetings so all staff could be clear on what the service was trying to achieve.

Culture

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

All staff we spoke with were positive about the culture and proud to work for the service. They described a culture of strong teamwork and caring for each other and gave examples of staff going above and beyond to support patients and each other.

The service shared monthly newsletters with staff that provided examples of best practice and positive news.

The service provided opportunities for career development through protected time for training, study days, conferences and the payment for higher education courses. They also rewarded staff through benefits such as private health insurance, counselling, physiotherapy and payment for professional fees.

Staff had worked for the service for considerable periods of time which reflected their views that they felt respected, supported and valued. They spoke very passionately about providing the highest quality of care and treatment and told us they felt privileged to be part of this.

Staff told us there was an open culture where they felt able to raise any issues or concerns.

End of life care

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear governance structure that outlined key lines of accountability and responsibility from clinical nurse specialists to directors. The meeting and committee structure ensured information flowed from hospital level through to board and back down to the hospital.

The lead operational nurse met weekly with the partnering hospital site matron following the weekly QAC meetings which ensured any information was passed down to hospital level in a timely manner.

The founder director attended quarterly medical advisory committee (MAC) meetings with partners to discuss issues and strategy. The MAC agenda included governance, mortality reviews and the quality of end of life care. The founder director told us this helped them determine whether their staff had provided care and treatment in a timely way.

The founder director also attended quarterly cancer board meetings with partners that shared key updates from numerous cancer boards. This included breast board, head and neck board, gynaecological board, urology board and skin board.

QAC meetings took place weekly and the committee provided monthly board assurance framework (BAF) reports to the board of directors. The BAF provided the board with assurance on how the service identified, monitored, escalated and managed concerns in a timely manner.

We reviewed minutes of board of directors' meetings and saw they shared key information on incidents, risks, action plans, performance and reviewed the service level agreements.

The service had shared governance arrangements with partners and provided assurance to the board of directors. The board received an overview of how the shared governance structures would ensure the partnership connected effectively and that the focus of leadership was appropriately balanced across all areas of responsibility. The shared governance arrangement also avoided duplication of work such as audits and ensured the partnership had a clear oversight of quality issues.

The service monitored service level agreements, audits and reported key performance indicators at the weekly QAC meetings. Finance and control of expenditure was discussed monthly at the board of directors meeting.

The service had processes in place to ensure clinical nurse specialists had up to date professional membership registration, indemnity insurance, evidence of qualifications and up to date disclosure and barring service (DBS) checks. They also had an effective system to monitor and review practising privileges for consultants. This included all appropriate evidence such as references, appraisals, qualifications, health declaration form and DBS checks.

Management of risk, issues and performance

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

End of life care

The service had service level agreements in place with the two hospital sites. The service held monthly meetings with the partners to cover relevant risks, incidents, patient feedback, mortality review feedback, shared learning from experience reports and shared reasons to be proud statements.

Services provided at the two hospital sites were discussed weekly in the QAC meetings which covered incidents, risks, investigations, activity and progress on quality improvement initiatives.

The service had a risk register which was monitored and updated by the lead operational nurse. The risk register was discussed weekly at the QAC meeting and shared with the board monthly. All risks had a score, review date, controls and risk owner assigned. Risks aligned with what staff and managers told us was on their worry list. The top 3 risks were cyber security, workforce and loss of business due to competition.

The service had a business continuity plan and systems to manage unexpected events. This clearly outlined actions to take in case of an emergency, key contacts and lines of responsibility.

Leaders told us that they promoted a culture of highlighting problems and reporting incidents so they could learn from them. They acknowledged that a significant advantage of being a small team was a close working relationship and the ability to respond to issues and mitigate risk quickly.

The service did not conduct their own audits. However, the clinical nurse specialists were regularly involved in the partnering audit schedule this included a monthly observational audit which had a section on end of life care. Audits such as end of life audit and preferred place of death were completed by the partners and shared with the lead operational nurse at weekly hospital matron meetings.

Leaders told us that the RAG inpatient triage system was scheduled to be audited and they had plans in place to do their own service specific audit led by the clinical nurse specialists and a consultant. The new audit would review responsiveness and effectiveness of interventions by the team.

At the time of inspection, all new patients were seen within 24 hours of first referral by a consultant. Similarly, all patients who needed urgent outpatient reviews were seen by a consultant or clinical nurse specialist within one week of initial referral. This was a mandatory target within their service level agreement.

The service received provider reports for their partner hospital site which benchmarked their performance against the other provider hospitals in the north and south of England. Leaders told us the benchmarking showed favourable and positive performance for their service. As a result of this, a new provider hospital had requested their support and guidance to implement a supportive and palliative medicine model at the new site.

Information Management

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

The service had systems in place for the safe storage, circulation and management of electronic and paper-based documents. Patient records were electronic and information technology systems were integrated and secure. Electronic systems (such as to store records and manage patient appointments) required password access.

End of life care

Service specific policies and guidelines were available for all staff to read on an online policy library. The policies we looked at were version-controlled, up to date and had periodic review dates.

There were systems in place to ensure data and statutory notifications were submitted to external bodies. The lead operational nurse, who was the registered manager, was responsible for submitting notifications to the Care Quality Commission. There had been no incidents that had been reportable over the previous 12 months.

Staff completed information governance training as part of their annual mandatory training. Records showed all staff had completed this training.

The lead operational nurse reported there had been no data breaches that were reportable to the Information Commissioner's Office (ICO).

Engagement

Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The partner hospital site was responsible for conducting patient surveys and they shared results with the service through site meetings. The service had its own specific patient satisfaction feedback form.

However, the service had not collected patient feedback through these forms for the previous 12 months. The lead operational nurse told us that they had made at least monthly visits to patients and partner hospital staff to gather feedback on the service and care. They told us that feedback had always been positive and was fed back to staff.

The lead operational nurse told us that they did not undertake staff surveys with the two clinical nurse specialists but instead held monthly meetings with time for open discussion on staff well being and satisfaction.

Leaders told us that they were in the process of developing feedback forms for partnering hospital consultants to gain feedback.

The service engaged with staff through quarterly newsletters and regular meetings. Staff had the opportunity to share ideas to help plan and manage the service. For example, staff had asked for a dedicated location for private phone calls to patients and families. The lead operational nurse raised this with the partnering hospital matron and secured private office space for phone calls.

The lead operational nurse was focused on staff health and well-being. Through the board of directors they had successfully added a comprehensive private health insurance benefit for staff.

Patients we spoke with said they had sufficient contact from staff and received regular follow up phone calls. They felt confident in contacting staff after discharge with questions about medication and symptoms of treatment.

Staff collaborated with partner organisations to help improve services for patients. This included signposting and referrals to community cancer support services, bereavement support services, GP's, hospices and community allied health professionals.

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Learning, continuous improvement and innovation

All staff were demonstrably committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and a proactive approach to implementing new models of care. The service shared work locally, nationally and internationally.

At the time of inspection, the supportive and palliative care service offered by the team was the only 24/7 service of its kind within a private hospital setting in the UK. The CEO told us that they were a pioneer in terms of early integration of palliative care. This was achieved through early referrals from diagnosis and providing care for patients across the whole cancer pathway. The service model has been adopted by hospitals, hospices and NHS trusts to address gaps in the workforce and implement the key assurances of consultant advice. It was now a national initiative in more than 20 cancer centres.

Leaders were keen to replicate this innovative model further and had recently been asked by another provider hospital to help implement the model at their new site.

The service had also been approached by health professionals in India and the Czech Republic who wanted to improve palliative provision in their country and use their expertise in palliative medicine.

The service received two Health Service Journal (HSJ) awards in 2021 and 2022, one for partnership with the NHS and one for partnership with 'not for profit' organisation.

The clinical nurse specialists provided targeted education for care after death and care in the last days of life to staff at partnering hospital sites. They had assessed the staff training needs and would be evaluating the training at the end. New staff members at partnering hospital sites, including students were also given the opportunity to shadow the clinical nurse specialists.

The clinical nurse specialists were also supporting the first Enhanced Supportive Care model within the private health insurance market. The private health insurance was offering a clinical nurse specialist led consultation to every member who received a diagnosis for incurable cancer. Several other major health insurers have shown interest in developing a similar support service for their members.

Leaders spoke passionately about growing palliative care services in the UK to have more involvement with patients in other parts of the cancer spectrum. They understood the significant need for more palliative care but with the challenge of limited funding. They were committed to making a difference to health inequalities and improving innovation across the health and social care sector to benefit patients where access is poorer.

The service was committed to improving services by learning from when things went well or not so well. Mortality reviews were undertaken by the partner hospital site to share good practice and identify opportunities for learning. For example, one mortality review had shown the service could have had more involvement in the provision of care and treatment for a small number of patients. The action plan established an additional afternoon MDT meeting for staff to discuss all inpatients and this had been fully implemented.

The service received quarterly 'learning from experience reports' from partners and consultants attended quarterly consultant forum meetings. We reviewed meeting minutes which showed shared learning from consultants across England and Ireland on areas such as medication, business growth, policies and reviewing seizure management calls. The review aimed to improve reliability in terms of advice being given by consultants remotely and to reduce variability.

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The service had a number of improvement plans including a new electronic referral system for the specialist palliative care team. The aim was to promote early referrals and improve overall experience of service users. Other plans were to expand bereavement support and to audit the clinical nurse specialists activity and report on responsiveness.

The founder director was also president of UK Association of Supportive Care in Cancer (UKASCC) registered charity with clinicians all over the country including pharmacists and allied health professionals. They were also involved with the Association for Palliative Medicines, Royal College of Physicians to help clinicians with accreditation to deliver a whole pathway of care like this service.

Leaders told us they tried to ensure they had a national profile in terms of attendance at national conferences. The MD had presented at two national conferences this year on the topics of workforce in supportive and palliative care and delivered a workshop on the role of MD.

The CEO and MD had recently been invited to speak at the British Journal of Hospital Medicine Conference. They spoke about the challenges of delivering remote palliative and were part of an expert panel discussing the future of palliative care.