# Genesis Care, Oxford

## Quality Report

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

## Ratings

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

### Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

# Summary of findings

## Letter from the Chief Inspector of Hospitals

GenesisCare Oxford is operated by GenesisCare UK. The centre provides treatment to patients over 18 years old, this includes chemotherapy, radiotherapy, diagnostic imaging and outpatient consultations. We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 3 September 2019.

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.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We inspected the medicine core service which included chemotherapy and radiotherapy treatments, this was the main service provided at the centre. We also inspected diagnostics which included the MRI and PET-CT and CT suites.

The service also provides a consultant led outpatients service. At the time of our inspection this did not employ any dedicated staff apart from one bank clinical nurse specialist who covered the breast clinics and a health care support worker from another department to provide assistance and chaperone when required.

Where our findings on medicine, for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the medicine service level.

**Services we rate**

We rated it as **Outstanding** overall.

- Patients were protected by a comprehensive safety system and there was a focus on openness, transparency and learning when things went wrong.
- Staff not only meet good practice standards in relation to national guidance, they also contributed to research.
- Compliance with medicines policy and procedure was routinely monitored and action plans were always implemented promptly.
- The provider had a sustained track record of safety supported by accurate performance information. There was ongoing, consistent progress towards safety goals reflected in a zero-harm culture.
- There was a genuinely open culture in which all safety concerns raised by staff and people who used the service were highly valued as being integral to learning and improvement. All staff were open and transparent, and fully committed to reporting incidents and near misses.
- People were respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.
- Feedback from people who use the service, those who were close to them and stakeholders was continually positive about the way staff treat people.
- People told us that staff went the extra mile and their care and support exceeded their expectations.
- Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.
- People's emotional and social needs were seen as being as important as their physical needs.
- The service had enough staff to care for patients and keep them safe.

# Summary of findings

- Staff had training in key skills, understood how to protect patients from abuse.
- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- Staff managed medicines well.
- Staff collected safety information and used it to improve the service.
- Staff managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait long for treatment.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.
- There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.
- Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.
- There was a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviewed how they functioned and ensured that staff at all levels have the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

## Overall summary

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Medical care (including older people's care)** | Outstanding ☆ | Medical care services were the main proportion of activity at the centre.<br>We rated this service as outstanding in caring and well led and good in safe, effective and responsive. |
| **Outpatients** | Outstanding ☆ | Outpatient services were a very small proportion of hospital activity. The main service was medical care. Where arrangements were the same, we have reported findings in the medical service section.<br>We rated well led as outstanding and safe and responsive and as good. We were unable to rate caring or effective due to limited data. |
| **Diagnostic imaging** | Good ● | Diagnostic imaging services were a small proportion of hospital activity. The main service was medical care. Where arrangements were the same, we have reported findings in the medical service section.<br>We rated this service as good in safe caring and responsive and outstanding in well led.<br>We were unable to rate effective due to limited data. |

# Summary of findings

## Contents

Outstanding ☆

# GenesisCare, Oxford

**Services we looked at;**
Medical care; Outpatients; Diagnostic imaging.

# Summary of this inspection

## Background to Genesis Care, Oxford

GenesisCare Oxford is operated by GenesisCare UK and opened in 2014. It is a private cancer treatment centre which primarily serves the communities in Oxford. It also accepts patient referrals from outside this area. Services were delivered across two buildings, Beaumont House and Orion House which are situated next to each other.

The hospital has had a registered manager in post since 2014, the most recent registered manager was registered with the CQC in July 2017.

We inspected this service on the 3 September 2019, this was GenesisCare Oxfords' first inspection.

Services and equipment provided at the centre are;

- Positron emission tomography–computed tomography(PET-CT). This is a nuclear medicine technique which combines a PET and an x-ray CT scanner, to acquire a sequence of images from both devices in the same session, which are combined into a single superposed image.
- Computed tomography (CT) scanning.
- Radiation therapy. A single linear accelerator (LINAC) is
- A 3 Tesla magnetic resonance imaging (3T MRI) service, with four uptake rooms. A 3T MRI has a stronger magnet and makes better images of organs and soft tissue than other types of MRI do. It is used to make images of the brain, the spine, the soft tissue of joints, and the inside of bones and blood vessels.
- A medical oncology service provides systemic anti-cancer therapies (SACT) for solid tumour and haematological malignancies.
- A consultant led outpatient service which offer new patient, on-going treatment reviews and follow up appointments for oncology, haematology, neurology, urology and gynaecology.

## Our inspection team

The team that inspected the service comprised a CQC lead inspector and two specialist advisors with expertise in diagnostics and oncology nursing. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

## Information about Genesis Care, Oxford

At the time of our inspection the main services provided at GenesisCare Oxford were chemotherapy and radiotherapy, this has been reported under the medicine core service. MRI and CT and PET-CT services were also provided at the centre and are reported under the diagnostic core service. Patients also had access to consultant led outpatient clinics which have been reported under the outpatient's core service.

The centre provided/ funded a complementary wellbeing clinic run by a registered charity. Patients could access counselling and treatment rooms at the centre or could receive telephone counselling.

The centre was registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning
- Treatment of disease, disorder or injury

# Summary of this inspection

During the inspection, we visited the diagnostic and radiotherapy department and the chemotherapy suite. We spoke with 16 staff including registered nurses, radiotherapy and diagnostic staff, reception staff, a consultant and senior managers. We spoke with six patients and two relatives. During our inspection, we reviewed three sets of patient records and two medicine charts.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the centres first inspection since registration with CQC.

Activity (April 2014 to March 2015)

- In the reporting period June 2018 to May 2019 There were 3458 outpatient attendances, 2945 radiotherapy attendances, 308 MRI and CT attendances and 672 Chemotherapy department attendances.
- At the time of our inspection 12 clinical oncologist, two medical oncologists, 11 radiologists, one urologist, one dermatologist, four haematologists, one GP, one gynaecologist and one surgeon worked at the hospital under practising privileges.
- There was a regular resident medical officer (RMO) who attended the clinic on treatment days for chemotherapy and contrast scans.

The service was run by one centre leader who was supported by a deputy centre leader. There were;

- Five radiotherapists
- Five diagnostic staff
- Four physics and dosimetry staff,
- Two clinical trials staff
- Three pharmacy staff
- Three registered nurses
- One care assistant
- Eight administration/reception staff, as well as having
- One clinical nurse specialist worked as a bank nurse

Track record on safety

- No-never events
- No-serious injuries
- No-moderate harm
- 76-low harm clinical incidents
- No- deaths
- Nine-non-clinical incidents

No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (c.diff)

No incidences of hospital acquired E-Coli

One complaint

**Services accredited by a national body:**

ISO 9001 accreditation for oncology services.

The centre has Macmillan Quality Environment Mark.

**Services provided at the hospital under service level agreement:**

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

Good

We rated it as Good because:

- The service had systems and processes to keep patients safe.
- Staff managed medicines safely and the service routinely monitored compliance.
- It was easy to track patients' care and treatment as records were well organised and maintained.
- Staffing levels were safe and staff had the right skills to care for patients.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.
- The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service managed patient safety incidents well. Staff recognised incidents and reported them safely. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

However

- Mandatory training was not completed by all members of staff

### Are services effective?

Good

We rated it as Good because:

- The service provided care in accordance with evidence-based guidance.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- 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.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.

# Summary of this inspection

## Are services caring?

Outstanding 

We rated it as Outstanding because:

- The centre went above and beyond to ensure its patients and relatives/carers received kind and compassionate care and provided a free wellbeing service.
- Feedback from patients continually confirmed that staff treated them well and with kindness.
- The centre had a calm, relaxed and friendly atmosphere contributing to the overall feeling of wellbeing.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- A free taxi service was also available for those patients undergoing daily treatment or feeling too unwell to drive and to take the pressure off family members.
- Staff continually provided emotional support to patients to minimise their distress. Staff we spoke with valued patient's emotional and social needs.
- Patients had their physical and psychological needs regularly assessed and addressed. People's emotional and social needs were seen as being as important as their physical needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- Staff worked hard to empower patients and their relatives, made sure patients and their relatives were active partners in their care

## Are services responsive?

Good 

We rated it as Good because:

- The service planned care to meet the needs of local people and made it easy for people to give feedback.
- 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.
- The service planned and provided care in a way that met the needs of local people. It also worked with others in the wider system and local organisations to plan care.
- The centre had a holistic and person-centred approach to care and worked with a charity who provided on-site complementary wellbeing services.

## Are services well-led?

Outstanding 

We rated it as **Outstanding** because:

# Summary of this inspection

- The centre leadership team was highly visible and supportive. This was reflected in how the staff spoke highly of the culture.
- There was compassionate, inclusive and effective leadership at all levels.
- Staff understood the service's vision and values, and how to apply them in their work.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.
- Leaders operated effective governance processes and used systems to manage performance effectively.
- 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

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Good | Good | ☆ Outstanding | Good | ☆ Outstanding | ☆ Outstanding |
| Outpatients | Good | Not rated | Not rated | Good | ☆ Outstanding | ☆ Outstanding |
| Diagnostic imaging | Good | Not rated | Good | Good | ☆ Outstanding | Good |
| Overall | Good | Good | ☆ Outstanding | Good | ☆ Outstanding | ☆ Outstanding |

Outstanding

# Medical care (including older people's care)

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

## Are medical care (including older people's care) safe?

Good

We rated safe as **good.**

**Mandatory training**

**The service provided mandatory training in key skills to all staff and staff worked hard to achieve compliance, however not everyone in the centre had completed it.**

- Staff accessed their mandatory training by a mixture of e-learning and practical sessions and received mandatory training in a variety of topics such as basic life support, conflict resolution, infection control, duty of candour and fire safety. The centre set a compliance level of 95% and at the time of our inspection overall compliance was 92%, this was above the GenesisCare UK overall compliance which was 82%
- There were four staff members employed in the chemotherapy unit at the time of our inspection.Except for two members of staff whose e-learning medical gas training had recently expired, all were up to date with all their e-learning mandatory training. Except for one member of staff whose practical manual handling had expired all were up to date with their practical mandatory training requirements.
- There were five members of staff in the radiotherapy department all were up to date with their e-learning and practical mandatory training requirement, except for one member of the team whose immediate life support (ILS) training had expired.
- The centre employed resident medical officer (RMOs) through an external agency. The RMO provided cover to the centre during the clinic hours. As part of their agreement it was the agency who provided the RMOs with the relevant mandatory training. The centre leaders monitored this, and we reviewed seven RMO's most recent advanced life support (ALS) training certificate which were all within their expiry date.
- Those staff with practicing privileges had to provide evidence of completion of their mandatory training from their substantive NHS trust employer This information was held on a database at the centre which when we reviewed showed all but one had provided in date information

**Safeguarding**

**Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.**

- The service provided yearly safeguarding training as an online training package. Qualified staff received safeguarding adults and children level two. The staff in the chemotherapy and radiotherapy departments were fully compliant at the time of our inspection.
- Non-clinical staff received level one adult and children safeguarding training. All non-clinical staff had completed both elements of the required training.

- The centre leader had been trained to safeguarding level two adults and children and safeguarding adults' level three practical. However, at the time of our inspection the level three practical element had expired. This had been bookedfor October 2019 and in the interim the deputy leader had in date level 3 training.
- Staff knew the centre leader was the lead for safeguarding and knew how to contact the corporate safeguarding lead trained to level four safeguarding adult and children. This met the intercollegiate guidance for safeguarding children.
- Staff knew where to access the centres safeguarding policies and had easy access to electronic versions on the provider's internal intranet. The policies were in date, version controlled and reflected national guidance.
- The staff we spoke with had not been involved in any safeguarding issues at the time of our inspection. However, all those staff we spoke with demonstrated an understanding of their safeguarding responsibilities and procedures, which included female genital mutilation (FGM) in the event of any concerns. This aligned with the service's safeguarding policies for adults and children.
- Safeguarding was a standardised agenda item discussed at the monthly centre meetings.
- There were no safeguarding concerns reported to CQC over the last twelve months.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

- The centre had in-date, version-controlled policies about effective infection control and hygiene processes. Staff knew how to access these via the centres electronic system, for ease of use, links to other polices were embedded into the overall infection control policy which was in-date and version controlled.
- Supplies of personal protective equipment (PPE), such as disposable gloves and aprons, were available in each department. We observed all staff used the correct PPE when providing care and treatment to patients.
- Equipment such as observation machines, trolleys and weighing scales were cleaned after use and a green 'I am clean' sticker attached. Every area we visited used the same method and all equipment we checked had a green label on it indicating it had been cleaned and was ready for use.
- We reviewed the cleaning rota for the medical linear accelerator (LINAC) in the radiotherapy department, for the month of August and all areas were checked and cleaned every day.
- We reviewed the chemotherapy unit cleaning task list for August and saw all areas were ticked as cleaned every day that the unit was open.
- Alongside daily cleaning lists, the centre staff completed a weekly spot check environmental cleaning list, which we saw had been fully completed for the 20 August 2019.
- The centre carried out a six-monthly infection control audit which included an audit of the general environment, those areas cleaned by staff and cleaners and waste disposal. This was last completed in March 2019 and the centre was 99.3% compliant.
- Staff, patients and visitors had access to wall mounted and portable hand sanitiser gel dispensers at the entrance to the centre, every department and relevant points throughout the department. We observed all staff used these.
- We observed, all staff decontaminated their hands in line with World Health Organisations (WHO). Five moments of Hand Hygiene (2009).
- Hand hygiene audits were completed monthly, the results for August 2019 showed all staff were bare below the elbows and complied with good hand hygiene practice.
- Staff received e-learning and practical mandatory training in infection prevention and control. All staff but one had completed their e-learning requirements and six staff members had either expired or no dates of completion of the practical element. This meant staff may not have been up to date with current practice.

**Environment and equipment**

# Medical care (including older people's care)

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

- The facilities, environment and equipment were well maintained. All the areas we visited were spacious, light, airy and clutter free. The chemotherapy unit had received the Macmillan Quality Environment Mark (MQEM). The MQEM is a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer. It is the first assessment tool of its kind in the UK.
- The centre had an open-plan reception/ waiting area on the ground floor and reception staff always present. Patients waited in this are prior to be called into restricted areas.
- Equipment which may be required in an emergency wasstored on dedicated trolleys available oneach floor in the centre. The trolleys were tamper-evident to reduce the risk of equipment being removed and not available in an emergency. Staff carried out daily and weekly checks of this equipment to ensure it was ready for use in an emergency. We checked trolleys in the chemotherapy suite and the radiotherapy department, all were visibly clean and consistently checked in line with the policy. We saw information was located with or above the trolleys, providing guidance for staff about the emergency procedures and action to take, such as if sepsis was indicated.
- Stickers on equipment and machinery identified the last service date and when the next service was due. We examined four items of equipment which had been serviced or maintained within the last 12 months.
- In all areas we inspected staff complied with the Department of Health, Health Technical Memorandum 07/01, safe management of healthcare waste (2013). All waste was segregated in different coloured bags. GenesisCare UK had a waste management standard operating policy which outlined to staff the processes and procedures to be followed to ensure compliance.
- Containers were provided for the safe disposal of sharp equipment, such as needles and cannulas. We observed these were labelled correctly on assembly and when ready for collection. None of the containers were overfilled, reducing the potential of needle stick injury.
- The LINAC had daily quality assurance processes to ensure the suite was safe for use. QA processes were completed daily by the lead of the departments. We reviewed the checks from 2 September to the 16 September 2019, all were completed and passed and stored electronically. Any issues noted were therefore logged for future visits by the engineers.
- The LINAC had all service records recorded and signed off by service lead and service engineer. The latest service was completed in August 2019 .
- There were fire exit signs and fire extinguishers throughout the premises. All fire exits, and doors were kept clear and free from obstructions. The centre tested fire alarms weekly. Staff completed two yearly mandatory practical fire safety training and yearly e-learning fire safety. One member of staff's practical element had expired, and another had no date entered on the spreadsheet. One member of staff e-learning requirement had expired.
- There was an in-date version-controlled health and safety management policy and a Control of Substances Hazardous to Health (COSHH) policy. Staff stored COSHH items securely in a locked cupboard.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

- All the centre staff from every department attended a daily huddle led by the centre manager. The huddle included an overview all departments and discussed and identified a variety of quality and safety issues.We attended the morning huddle along with 14 members of staff where the centre manager identified who was responsible for what role in the event of patient deterioration. Roles included resuscitation, airway, intravenous access, oxygen, runner and scribe. This meant that all staff knew their roles in the event of an emergency. Patient activity was also discussed for example those patients who required urgent scans. Fire procedures were discussed and the fire marshal for that day was identified.

- Posters were displayed in the radiology department to ask patients to inform staff if they thought they might be or were pregnant. These posters had the information displayed in multiple languages.
- Staff received teaching on sepsis during their Immediate Life support training and used the National Early Warning Score (NEWS) system to monitor for patients who were deteriorating and prompt the escalation of care. They followed the sepsis six policy and the United Kingdom Oncology Nursing Society (UKONS) management framework for the initial management of an emergency.
- Staff used 'prompt' cards based on the 'situation, background, assessment and recommendation' tool. This prompted appropriate and effective communication as it focused the caller to discuss the situation, background, assessment and their recommendation (SBAR) during an emergency. The tool allowed effective and timely communication between individuals from different clinical backgrounds and templates were kept on the resuscitation trolleys.
- The centre was open from 8am to 5pm Monday to Friday, however for those patients who had treatment at the centre could access a telephone hotline (triage) which operated 24-hour day, seven days a week. This was in line with UKONS guidelines. The 24-hour triage service was delivered by the chemotherapy nurses on a rota basis. Activity from the 1June 2018 to 31 May 2019 recorded that 34 patients called the out of hours triage line. The centre had started reviewing this data from January 2019 for future audit and review purposes. If a member of staff was called several times overnight or for a long period of time, they would try to start work later the following day.
- As required by the Health and Safety Executive (HSE) who regulate the Ionising Radiations Regulations 2017 (IRR99), all areas where medical radiation was used were required to have written and displayed local rules which set out a framework of work instructions for staff. These local rules were displayed throughout the department. All relevant staff had read and signed the local rules policy, which applied to all persons who could be exposed to ionising radiations.
- There were processes in place to ensure the right person received the right scan at the right time. Staff completed a six-point check of name, date of birth, address, body part, clinical information and previous imaging checks in line with the legal requirements of IR(ME)R to safeguard patients against experiencing the wrong investigations.
- All patients who were undergoing chemotherapy were given a national chemotherapy alert card. This informed patients to contact the 24hour alert line if they suffered from suspected sepsis or present the card to anyone who was going to treat them.
- The centre had service level agreement (SLA) with a local NHS trust in case of an emergency or need for an acute admission for example spinal cord compression or neutropenic sepsis. The SLA clearly defined the emergency and acute admission pathways for those patients under the care of GenesisCare consultants.
- Staff had access to risk assessments on line specifically for the individual departments needs. For example, the breakdown of the LINAC machine, the safe use of radiotherapy couches and the risk of electrocution whilst staff used the water bath for moulding treatment masks.
- Staff in the chemotherapy unit and radiotherapy departments completed risk assessments for all patients such as the venous thromboembolism, pressure ulcer and falls. We saw staff had completed and updated all risk assessments from the two sets of electronic records we reviewed. Patient's electronic records showed alerts for any identified clinical risks, such as falls or malnutrition.
- Radiographers performed daily reviews on their patients and liaised with the oncologist or GP if patients required medical attention for symptom control. Senior staff told us that patients who received chemotherapy could spend up to eight hours at the centre in one time and would receive a comprehensive pain, hydration and nutrition review. Nurses ensured that an up to date weight was recorded Blood results were checked by the nurses before proceeding with chemotherapy and any evidence of dehydration was escalated to the RMO on-site who could prescribe fluids.
- We spoke with the clinical trials pharmacists/ co-ordinator who told us two trials were being recruited into at the time of our inspection and one had just started. We discussed how the process worked and how

it was monitored to ensure any risks were identified. We were told there were specific inclusion and exclusion criteria which were assessed during the recruitment stage, all patients had cooling off period prior to informed consent. All stages were discussed during the monthly research committee meeting, chaired by a haematologist, attended by the clinical trails co-ordinator and the pathology manager.

**Staffing**

**The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

- The chemotherapy department consisted of 3.6 WTE staff members. There was one lead nurse/researcher, 2 senior nurses and one support worker. They were supported by a bank breast clinical nurse (CNS) specialist.
- As the service developed, new clinical nurse specialist (CNS) roles had been recruited into. At the time of our inspection, a head and neck CNS and a neuro-oncology CNS were due to start working for the centre. Staff also told us should they need to, they could access CNS' from other GenesisCare centres which were relatively close by.
- Radiotherapy staffing consisted of five WTE radiotherapists.
- The service was supported by eight administration and reception staff.
- The centre was managed by a centre leader who was supported by a deputy.
- We attended the daily huddle which was co-ordinated by the centre leader and attended by all staff. During this meeting staffing for all departments for the day and the week was discussed and any issues identified.
- Weekly operational calls with the director of operations, centre leaders and function leads, supported any additional requirements or changes in planned activity. Staffing was discussed and if necessary staff came from other centres to work.

**Medical staffing**

**The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction**.

- The centre had access to agency resident medical officers (RMO). RMOs were in the building during chemotherapy treatment days and contrast scans.
- The agency had a service level agreement with the service which made sure RMOs had the skills and competencies to perform their role such as mandatory training and revalidation. GenesisCare UK also required that all RMOs must have completed The Resuscitation Council (UK), Advanced Life Support (ALS) training. We saw seven RMO's ALS certificates all of which were in date.
- At the time of our inspection the centre had 34 physicians working under practising privileges. This included clinical and medical oncologists, dermatologists, haematologists. Practising privileges is an authority granted to a physician by a hospital/ services governing board to provide patient care. The medical advisory committee (MAC) monitored all staff with practicing privileges. The centre raised and reported any concerns, including competencies, about consultants through the MAC.
- Practicing privileges were monitored and tracked on a centre compliance spread sheet and any physician whose requirements were out of date or near renewal would be contacted. We reviewed the spreadsheet and saw one haematologist appraisal had expired at the beginning of September and one oncologist and one radiologist's disclosure and baring service (DBS) had expired in July 2019. We were informed that the appraisal had been booked and the DBS were in the process of being actioned at the time of our inspection. This had been sent to the quality and safety team for renewal.

**Records**

# Medical care (including older people's care)

**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.**

- The centre used an electronic care records system and only authorised staff could access these with a secure password through the centre's online system. Senior staff told us that passwords were managed centrally for security.
- Some paper records of patient contact details and chemotherapy treatments were kept securely locked away onsite. This meant that in the event of a network outage staff would be able to proceed with treatment as a paper copy of the approved prescription would be held in addition to the patient record.
- All consultants with practicing privileges had remote access to the electronic system and home working arrangements for reporting. This reducing the need for hard copies of patient records to be taken offsite. Consultants were registered independently with the Information Commissioners Office (ICO), which is the independent regulatory office in charge of upholding information rights in the interest of the public.
- We reviewed two sets of electronic records which showed staff had fully completed them, were legible, up to date and stored securely. Each record contained a personalised care plan and safely updated risk assessments such as the risk of venous thromboembolism, pressure ulcer and falls.
- The radiotherapy department used an electronic record and verify system which was used along the patient pathway and inter departmentally so that all members of the multi-disciplinary team could access patient information and review what treatment scan was required or had been completed.
- Radiotherapy treatment would not be possible in the event of network outage as the record-and-verify system would not operate under those conditions. The centre would refer to the local in-date business continuity plan should an incident occur.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

- The chemotherapy nursing staff team delivered vascular injectable and oral systemic anti-cancer therapy (SACT) to patients. The service was supported by a pharmacy team who screened prescriptions and checked and issued SACT products, which were all prescribed using an electronic prescribing platform and ordered from an external supplier.
- The pharmacy team had one part time lead research pharmacist, one full time oncology pharmacist and one pharmacy technician they were overseen by the services principal pharmacist.
- The pharmacy staff scanned in the receipt of new medicines in line with Falsified Medicines Directive legislation, which came into force in January 2019. This aimed to increase the security of the manufacturing and delivery of medicines across Europe.
- All medicines were kept in locked cupboards within an air-conditioned locked treatment room. Refrigerated medicines were kept in temperature-controlled refrigerators which were monitored and checked daily. The centre did not keep controlled drugs.
- The pharmacy team put together the treatment regime which was prescribed by the consultants. The pharmacy department had a comprehensive checking procedure for the management of all chemotherapy prescriptions, to ensure the right patient received the right medicine at the right time. This included checking the correct drug was prescribed with the correct clinical indication, that the drug was tailored specifically to the patient renal (kidney) function, weight and body surface. Part of the comprehensive checking process was to verify patient consent, check a referral was in place and to check the insurance company had agreed the treatment plan.
- Once this regime had been built it was checked and confirmed by the consultant and the principal pharmacist, approved electronically and validated. This process was mirrored for those patients who were part of clinical trials.
- A member of the pharmacy team met with patients and their relatives prior to the start of each of their treatments, to help build the ongoing treatment plan. During these meeting, treatment regimens and their

side effects were discussed. Treatment regimens were discussed with the consultants, however variations to counteract side effects could be altered by the RMO where necessary.

- Staff could access a version-controlled medicines management policy which was in the process of being reviewed as it had expired at the end of July 2019. This policy explained the roles of the medicines management committee (MMC), classification of medicines and that no GenesisCare UK sites were registered to hold controlled drugs.
- The pharmacy staff recognised that the amount of medicines that some patients required was potentially confusing, especially when some had to be taken at a certain time. Staff developed a patient specific medicine calendar and plotted what medicine should be taken and when. Patients told us that the pharmacy team were 'excellent and the spread sheet with colour coded information of when to take what tablet was really helpful'.
- The chemotherapy department had an extravasation kit in case of any emergencies. Extravasation occurs whenintravenouslyinfused, and potentially damaging, medications leak into the extravascular tissue around the site of an infusion. This meant prompt action could be taken if this occurred
- GenesisCare UK's medicines management committee met quarterly and this meeting was attended by all pharmacists and department leads from the genesis UK centres. We reviewed the minutes from meeting in May 2019 and saw that incidents were a standardised agenda item.

**Incidents**

**The service managed patient safety incidents well. Staff recognised incidents and reported them safely. 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.**

- GenesisCare UK had an in-date, version-controlled incident, accident and near miss policy which staff accessed electronically.
- Staff showed a good understanding of what incidents should be reported and how they would raise an incident using the electronic reporting system. All staff we spoke with confirmed the service encouraged staff to report all incidents. Staff shared one example of lessons learned after a misinterpretation of an administration chart led to a drug error. This was identified immediately, there was no harm to the patient, the consultant was contacted straight away, and the patient informed, in line with the duty of candour.
- All staff understood the 'duty of candour' and described their responsibility related to it. The duty of candour is the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided. After the incident mentioned above a new administration and guidance form was developed and was in use at the time of our inspection
- Any incidents that may have occurred during the week or had actions outstanding were discussed during the daily huddle. This was held in the morning for all centre staff to attend and was minuted daily.
- The service reported;
  - No deaths or major incidences, serious injuries or never events,
  - Clinical incidents – 76 low harm, 0 moderate harm, 0 severe harm, 0 death.
  - Non-clinical incidents- 9
- Incidents were discussed during the monthly centre meetings, the minutes for May 2019 identifiedan increase in reporting was identified as a positive change. Incidents at each centre were then discussed at the Safety and Quality monthly meeting, as this was attended by all centre leaders it ensured learning across all centres was shared.
- If an incident occurred and a root cause analysis (RCA) was required than this would be discussed at the quality and safety meetings and learning shared across all the centres. When root cause analysis (RCA), were completed they included findings, contributing factors, recommendations and were signed off by the head of the department, centre manager, quality manager and the chief medical officer.

Outstanding ☆

# Medical care (including older people's care)

## Are medical care (including older people's care) effective?

Good

We rated effective as **good.**

**Evidence-based care and treatment**

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.**

- The service used a range of evidence-based guidance, legislation, policies and procedures to deliver safe care, treatment and support to patients. We saw care pathways followed nationally recognised recommendations such as the National Institute for Health and Care Excellence (NICE) guidance. Chemotherapy treatments were based on the United Kingdom Oncology Nursing Society (UKONS) guidance.
- Staff we spoke with and patient records showed staff followed NICE guidance on falls prevention, cytotoxic medicines, pressure area care and venous thromboembolism.
- Staff had access to policies and standard operating procedures (SOP) which referencednationally recognised guidance. Staff accessed SOPs and policies through an online system. We reviewed a sample of these,all were version controlled, in date and easily accessible for example a SOP for cytotoxic medicines. This included ordering, preparation, prescription, administration and disposal. Staff described they followed the clear guidelines in handling these medicines.
- Advanced, evidence-based technology in radiotherapy was used to reduce the side effects to other areas of the body which could be damaged during radiotherapy treatments. In line with the 'gold standard' recommendations of the NHS commissioning clinical reference group patients could access intensity-modulated radiation therapy (IMRT) which helped reduce long-term side-effects of radiotherapy. IMRT is an advanced type of radiation therapy used to treat cancer and noncancerous tumours.IMRTuses advanced technology to manipulate photon and proton beams of radiation to conform to the shape of a tumour. Volumetric modulated arc therapy (VMAT) is a type of IMRT. VMAT is a short, powerful but accurate burst of radiation to the tumour. The surrounding healthy tissue receives a much lower dose, reducing the risk of side-effects. VMAT can be used when the tumour is close to critical organs. It helps them avoid being damaged by radiation.
- The centre offered recently advanced radiotherapy services and had installed a SSGRT system which used a system of cameras to monitor patient movement during treatment. This piece of equipment meant the centre could provide tattoo-less treatment this was positive for many patients who viewed their tattoos as a constant reminder of their radiotherapy treatment. The SGRT also enabled the centre to use 'faceless' shells for head and neck radiotherapy treatment. This was a much nicer experience for patients as they no longer needed to wear full face masks and could open their eyes and feel less restricted.
- Deep Inspiration Breath Hold (DIBH) was also available at the centre, this was a technique used to treat cancer in the breast or chest wall. It is precisely targeted so there is less chance of damage to the heart and lungs.
- The service used image guided radiotherapy (IGRT) which is the use of imaging during radiation therapy to improve the precision and accuracy of treatment delivery.IGRTis used to treat tumours in areas of the body that move, such as the lungs. This technique enabled the area to be targeted and treated, accurately and reduced the risks of side-effects from radiotherapy.
- Stereotactic ablative radiotherapy treatment (SABR) was also offered as an alternative to surgery. This targets tumours in the body with high doses of radiation therapy. It destroys cancer cells with minimum damage to surrounding healthy tissues.
- The centre offered a hydrogelhelped to prevent damage to the rectumby pushing therectum away from the prostate, therefore creating a protective gap. Side effects could be reduced as the cancer cells could be accurately targeted while healthy tissue was protected.

- Clinical research and trials were offered to patients and there were systems and processes in place to ensure these were safe. One clinical trial had just started and a further two were in the process of starting at the time of our inspection.
- Patients who took part in clinical trials within GenesisCare were followed up long-term by the clinical and research teams and long-term results were documented as per trial requirements.
- GenesisCare UK had developed its own performance database which collected quality and performance data. This enabled internal performance benchmarking across all 12 UK centres sites. Information included patient satisfaction, incidents, complaints, concerns and compliments.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs.**

- Staff used the malnutrition universal screening tool to assess the nutrition and hydration needs of patients. This tool is a five-step screening tool to identify malnourished adults or adults at risk of being malnourished. Staff documented the assessment outcomes in the patient's care records.
- Staff told us that patients who received chemotherapy could spend up to eight hours at the centre in one time and would receive a comprehensive hydration and nutrition review prior to and during their treatment. Nurses ensured that any evidence of dehydration or nausea was escalated to the RMO on-site who could prescribe fluids or anti-sickness medicines. Staff would inform the patients GP should further follow up be required.
- The centre employed a dietician who held a clinic weekly. All patients who attended the clinic had access to the dietetic service if required. Patients could request to see the dietician at any point and were advised during the pre-chemotherapy assessment they had open access to a dietician if required during and after completion of their treatment.
- Patients undergoing pelvic radiotherapy were reviewed weekly by the clinical team who recorded their nutrition and weight status.
- Radiographers performed daily reviews on their patients and liaised with the oncologist or GP if patients required medical attention for symptom control, such as nausea.
- Drinks and a variety of snacks were available for patients. Staff at the centre listened to feedback from their patients and had varied the snacks on offer.
- The centre had refreshment dispensers which patients and visitors could access coffee, tea, water and biscuits.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain.**

- All patients in the chemotherapy suite had a routine review by the nurses and this included pain level and toxicities, all of which were which were recorded on an electronic database.
- The on-site pharmacist reviewed chemotherapy patient symptoms including pain and was responsible for checking all their medicine. Staff used a numerical pain score to assess patients' pain and would have certain pain killers prescribed when necessary. However, as the centre did not keep controlled drugs if a patient's pain required urgent attention and escalation, the RMO or pharmacist would contact the patient's clinician and/or GP for urgent pain medication review.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

- Genesis care had developed its own analytic database which enabled data from all 12 UK centres to be internally benchmarked.Monthly performance reviews included quality measures such as complaints, concerns, compliments and the centres' net promoter score (which represented patient satisfaction). The number of incidents and which department they occurred in were monitored alongside, severity, status (open or closed) and any trends or support required.
- The radiotherapy unit contributed data from each patient episode to the National Radiotherapy Dataset (RTDS). The purpose of the standard was to collect consistent and comparable data across providers of

radiotherapy services in England. This would provide intelligence for service planning, commissioning, clinical practice and research and the operational provision of radiotherapy services across England.

- The centre collected Patient Reported Outcome Measures () to monitor patient progress, facilitate communication between professionals and patients and help to improve the quality of. Patients were asked to complete questionnaires on their health and quality of life. The centre reported outcomes during radiotherapy treatment using toxicity scoring tools. Toxicities greater than grade 2 were flagged to clinicians, added to the electronic incidence reporting system and audited monthly by the clinical governance team.
- The centre had recently registered to contribute information to the Private Healthcare Information Network (PHIN) for benchmarking purposes. This network is the independent government organisation that holds information about private healthcare to improve quality.
- The chemotherapy unit submitted Systemic Anticancer Chemotherapy (SATC) data. The SACT dataset collects systemic anti-cancer therapy activity from providers and the world's first comprehensive database, which enabled treatment patterns and outcomes to be understood on a national scale. The chemotherapy unit caseload and total of chemotherapy patients receiving treatment and frequency was collated.
- The centre had an audit schedule to identify, monitor and drive quality improvement. Audits included, confidentiality, consent, control of substances hazardous to health (COSHH), health and safety, display screen equipment (DSW), infection control, medical gas security and medicines management. Out of the 25 areas of audit, 16 had reached 95% and above compliance and the remainder had achieved an amber status all of which were 76% and above. There were no areas that had achieved a red status.

**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.**

- The service appraisal period ran from June to July each year. In the reporting period from July 2018 and July 2019, 100% of medical staff, nursing staff and healthcare assistants had completed their end of year appraisals. Staff reported appraisals were a positive process, where goals were set and monitored.
- Staff reported they received clinical supervision and one to ones each month or sooner when required.
- Nurses in the chemotherapy department were expected to and had completed competencies and nationally recognised specialist training in the administration of chemotherapy treatment.
- Radiographers were trained to assess needs and provide supportive treatments such as mouthwashes, anti-diarrhoeal medications and skin emollients for symptomatic control.
- New consultants and RMOs underwent a registration process to be granted practising privileges and received an annual review to ensure their practice remained safe and within scope. The centres registered manager was responsible for the annual review of clinician practising privileges and responsible for advising the medical advisory board (MAC) if there were any concerns. This ensured clinicians continued to practice within scope, have up to date documentation and there were no issues with integrity or competence.
- All staff including bank members received an induction programme. New starters and bank staff completed a health and safety induction checklist the first day they started their job, and this ensured they knew what to do in an emergency. This included for example, restricted areas and hazardous areas and access to policies and procedures. We reviewed the bank members of staff induction checklist all of which had been signed off.
- Permanent staff received a comprehensive induction process and completed a 60-day induction programme called the 60 Day road map. The GenesisCare new employee experience.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Outstanding ☆

# Medical care (including older people's care)

- Multidisciplinary meetings (MDT) to plan the treatment pathways for patients were the consultant oncologist's responsibility.Consultants arranged for patients to be discussed at the consultants own NHS trust MDT, which they accessed as part of their NHS practice.
- Leaders told us for radical radiotherapy it was a mandatory requirement for consultants to confirm that an MDT discussion had occurred at the point of referral to treatment.For systemic anticancer therapies (SATC) it has been agreed by the chief medical officer and the clinical lead for medical oncology that a formal MDT discussion was required for first line treatment. We were told a copy of the MDT decision record was supplied and scanned into the electronic patient record.
- The centre told us that to improve the MDT process, an electronic MDT platform was being piloted for some radiotherapy and all neuro-oncology referrals. The intention was for this to be rolled out to all specialities such as head and neck, breast, haematology and urology to endure all patient discussions are recorded and take place.

**Seven-day services**

- The centre did not provide overnight beds and opened from Monday to Friday from 8am to 5pm. Outside these hours, the centre provided a 24-hour nurse led triage line to support cancer patients.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

- Health promotion leaflets were displayed in relevant areas throughout the centre these included healthy eating and advice on stopping smoking. There were advice leafletsand booklets for people living with cancer and brain tumours from well known cancer charities.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.**

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. At the time of our inspection all members of staff had completed their mental capacity practical training and their patient e-learning consent training.
- Whilst staff had received training on mental capacity they said they would not be likely to see patients with mental capacity issues in their service as they would be seen at the local NHS trust. However, should they have concerns about a patient's mental health or capacity to consent verbally to investigations they would discuss this with the centre manager and the consultant.
- Consent was a two-stage process and was checked again when the patient came for any form of investigation or treatment, this was signed by the patient and radiographer, scanned and uploaded to the electronic system.
- The centre completed a yearly consent audit and scored 100% in June 2019.

## Are medical care (including older people's care) caring?

Outstanding ☆

We rated caring as **outstanding.**

**Compassionate care**

**Staff truly respected and cared for patients with compassion. Feedback from patients continually confirmed that staff treated them well. Patients told us that staff went the extra mile and the care and support exceeded their expectations.**

- There was a strong, visible person-centred culture. Staff were highly motivated to provide care that was kind and offered dignity and respect. We observed numerous respectful and compassionate interactions between staff, patients and their relatives where each patient was treated as an individual and everyone had time to talk.
- Relationships between people who use the service, those close to them and staff are strong, caring,

respectful and supportive. We observed how staff were always pleasant and welcomed patients and their relatives to the unit and all staff showed a genuine interest in the day to day lives of their patients.

- We observed all patients were treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty in line with NICE QS15 Patient experience in adult NHS services Statement 1. This was reflected in how the centre was designed which ensured that people's privacy and dignity needs were understood and always respected, this included during physical or intimate care and examinations.
- The centre offered a free hydrogelhelped to prevent damage to the rectumby pushing therectum away from the prostate, therefore creating a protective gap this reduced some of the side effects specifically experienced during this treatment.
- All staff-maintained privacy, with closed doors and clear signage indicating the room was occupied. There were also curtains within each room to provide extra dignity and privacy where required. The clinic had private changing areas for all its departments.
- Interactions between staff, patients and visitors were respectful and considerate. We observed that all staff introduced themselves to their patients in line with NICE QS15 Statement 3. The centre had designated quiet rooms where staff, patients and their relatives could have private conversations or wait for treatments away from the waiting areas.
- Patients could have a chaperone and there were posters and laminated leaflets displayed across all the departments informing patients about their availability.
- The centre had a calm, relaxed and friendly atmosphere contributing to the overall feeling of wellbeing. Staff told us that there was a choice of music during treatments, there was access to television with movie channels, board games and colouring in, in treatment rooms and waiting areas.
- The centre collected friends and family (equivalent) data, results were consistently high. 100% of patients would recommend the services from December 2018 to March 2019, 93% for April 2019 and 91% for May 2019.
- Thankyou cards were displayed in the chemotherapy department, praising and thanking the staff for their hard work, for example ''thank you for giving me my life back'' and "I feel like I am being looked after by good friends and the day passes quickly with lots of laughs''

**Emotional support**

**Staff continually provided emotional support to patients to minimise their distress. All the staff we spoke with understood their patient's emotional and social needs. Staff embedded these in their care and treatment.**

- Patients individual needs and preferences were always reflected in how their care was delivered. Patients physical and psychological needs were regularly assessed and addressed, including nutrition, hydration, pain relief and anxiety. This was in line with National Institute for Health and Care Excellence, QS15 Patient experience in adult NHS services Statement 10.
- Staff understood how demanding both emotionally and financially, daily treatment trips to the centre could be on patients and their relatives. To ease this burden the centre provided a free taxi service. One patient told us how thoughtful and helpful this was, not just financially but it enabled their partner to continue going to work.
- The centre offered Surface Guided Radiotherapy Treatment (SGRT) system which provided tattoo-less treatment. Emotionally, this was positive for many patients who viewed their tattoos as a constant reminder of their radiotherapy treatment.
- Throughout all the patient and relative interactions, we observed how staff understood the impact a person's care, treatment or condition could have on their wellbeing, both emotionally and socially. Patients emotional and social needs were seen just as important as their physical needs. Free complementary therapies were offered to patients and their relatives at the wellbeing clinic.
- Patients told us how impressed they were with the centre, one patient told us ''It's not just the treatment it's the whole package" another patient told us "I get treated individually and do not feel institutionalised''

**Understanding and involvement of patients and those close to them.**

Outstanding ☆

# Medical care (including older people's care)

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

- Staff were fully committed to empower patients and their relatives and ensured they were active partners in their care. Patients told us staff were very knowledgeable and were able to signpost patients and their relatives to support groups, for example the myeloma support group which met once a month. Another patient told us that the staff were "brilliant, upfront, honest and provided information openly". They told us there was always time to talk during the appointment and they never felt rushed.
- Staff encouraged relatives or friends who wanted to know more, to understand their loved one's treatment and how to support the patient.
- The wellbeing clinic also offered telephone counselling for patients who were unable to attend the clinic or needed extra support
- In recognition of how complicated managing their medication wasthe pharmacy department and produced a toolto support the patients to manage this aspect of their care and to understand what they need to take when and how.A personalised calendar was given to patients to help with this, this included when medicines could be taken and had colour codes to help identification. Patients reported this as a great help, one patient told us how this had helped relieve the stress to themselves and their relative.
- The staff recognised how important good nutrition was and patients and their relatives were given a recipe book written by a recognised cancer charity.

## Are medical care (including older people's care) responsive?

Good

We rated responsive as **good.**

**Service delivery to meet the needs of local people**

**The service planned and provided care in a way that met the needs of the people who accessed the service. It also worked with others in the wider system and local organisations to plan care.**

- The services provided reflected the needs of the patients who accessed the service and ensured flexibility, choice and continuity of care. Staff worked around their patients work and family commitments to offer treatments and appointments. Pre-treatment appointments enabled patient to prepare for their chemotherapy and associated treatments such as blood tests, injections and other intravenous therapies.
- The staff on the chemotherapy unit worked with a local NHS Trust to ensure safe patient referral in the event of a patient's deterioration. Staff would also contact and work alongside a local hospice and patients GPs to ensure patients were supported in the community and continuity of care.
- The service continually ensured the clinic met patients' needs and patient opinion was gathered through a variety of channels, informal verbal feedback, patient experience survey and patient complaints. This feedback was discussed at focus groups, centre and team meetings and used to inform service improvement and redesign projects. GenesisCare also had a newsletter which included patient feedback, suggestions and compliments.
- Facilities and premises were innovative and met the needs of a range of people who used the service. The centre was light and airy with consultation rooms, treatment rooms, a recovery room and plenty of quiet/ private areas for patients to sit and have time alone. There was access to television with movie channels, and colouring in and board games in the waiting areas. There was ample private parking for patients, staff and their relatives and a taxi service free of charge.
- All rooms were clearly identified and had signs indicating when a room was occupied. Toilets had clear signs, and each had an alarm bell to call for staff.

**Meeting people's individual needs**

# Medical care (including older people's care)

**The service was tailored to meet the needs of individual people and were delivered in a way to ensure flexibility and choice. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

- The centre offered advanced radiotherapy treatments (SGRT) which considered more than the delivery of treatment but individual needs. SGRT enabled patients to receive head and neck radiotherapy treatment by a 'faceless' shell. This was a much nicer experience for patients as they no longer needed to wear full face masks and could open their eyes and feel less restricted. The SGRT system also meant the centre could provide tattoo-less treatment this was positive for many patients who viewed their tattoos as a constant reminder of their radiotherapy treatment.
- The centre offered a free hydrogelhelped to prevent damage to the rectumby pushing therectum away from the prostate, therefore creating a protective gap. Side effects could be reduced as the cancer cells could be accurately targeted while healthy tissue was protected.
- The centre had an induction loop for hard of hearing patients and clear signage throughout. There was disabled parking and wheelchair access and lifts to all floors.
- Staff at GenesisCare recognised and provided for their patients' needs before they arrived at the centre. A free taxi service was available for those patients undergoing daily treatment or feeling too unwell to drive and to take the pressure off family members.
- Translation services were available, and the centre had a wide variety of written patient and carer information. Large print and easy read materials could be obtained when required.
- The centre had recognised that understanding private medical insurance arrangements and funding of treatments could be complex and increase anxiety at an already stressful period in theirs and their family's lives. Business support staff were allocated specifically to patients to help navigate them through this complicated and sometimes stressful process.
- The centre had a holistic and person-centred approach to care and worked with a charity who provided on-site complementary therapy services. Staff carried out holistic needs assessment to make sure patients received their preferred choice of therapy.
- Specialist equipment such as 'cold caps' (scalp cooling treatment), were available. Information leaflets about wig services was available throughout the centre alongside booklets on a wide range of cancers, chemotherapy induced symptoms, services available to support the effects of living with cancer and dealing with its emotional effects.
- Feedback from patients and carers was used to shape the services and provision of care and treatment at the centre. All patients who finished their treatment pathway were asked to complete a comprehensive questionnaire.

**Access and flow**

**People could access the service when they needed it and received the right care promptly.**

- Detailed reporting on 'time to treat' was a key performance indicator for GenesisCare Oxford, as well as at a wider corporate level. The centre dashboard identified trends and outliers, and benchmarking againstinternal key performance indicators (KPIs) as well as against national guidelines and individual doctors' performance.
- The 'time to treat' dashboard provided a breakdown of patient waiting times for different stages of the radiotherapy pathway. We reviewed the dashboard from January to June 2019 where detailed reporting was undertaken at each step in the booking process, as well as at an individual doctor level. In August 2019 the centre assessment to treatment time was 6.6 days, compared to 7.7 days nationally. The dashboard showed that in March, May and July 2019 time to treat was just above 7.7 days.
- Time to treat' performance was discussed in multiple forums, this included the weekly centre leader dashboard meetings, monthly operations meetings and one-to-one reviews with the centre team.
- There were 11 cancelled procedures within the reporting period of June 2018 to May 2019. Of these cancellations 100% of patients were offered another appointment within 28 days of cancellation.

- If a patient failed to attend their clinic appointment it was recorded electronically, and the patient's consultant informed. The data supplied for the periods of 1 July to the 30 August 2019 showed there had been no failure to attend.

**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. The service included patients in the investigation of their complaint.**

- The service received one complaint in the reporting period June 2018 to May 2019 was not reported to the ISCAS (Independent Healthcare Sector Complaints Adjudication Service).
- A recent change made after a complaint was to review and improvethe MRI pre-authorisation workflow following a complaint that preauthorisation did not cover the whole cost of the scan.Confirmation of authorisation is now confirmed prior to the day of appointment.
- Complaints and satisfaction comments were discussed as a standardised agenda during the monthly staff meeting. We reviewed meeting minutes and saw comments made about unclear signage for parking were in the process of being addressed. There was also the opportunity to discuss any complaints and learning for the wider team at the monthly safety and quality committee meeting.
- Staff had access to the GenesisCare UK corporate concerns and complaints policy which was in date and version controlled. Staff told us they would try to resolve a complaint at local level before it was escalated.
- The registered manager of the centre, the operations director and the quality manager were all responsible for the oversight and management of complaints. The centre reported all complaints to the corporate's chief medical officer. The team worked in collaboration to ensure patients were informed, lessons learned and that the complaint was managed in line with policies. The aim was to acknowledge all complaints within two days of receiving them, a final response would be provided within 20 days of the complaint, senior staff told us they were achieving their targets. Depending on the complaint if a 20-day response was unrealistic, then patients would be notified of the delay, the reasons for the delays and the date they should expect a full response

## Are medical care (including older people's care) well-led?

Outstanding ☆

We rated well led as **outstanding.**

**Leadership**

**Leaders had the integrity, 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. Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.**

- The centre had a clear accountability and leadership structure. Managers at all levels had the right skills and abilities to run the service providing high-quality sustainable care.
- GenesisCare Oxford was managed by a centre leader, who reported directly to the director of operations who sat on the GenesisCare UK Leadership Team. The centre leader was supported by a deputy centre leader. Each departmental leads /senior staff reported to the deputy and the centre lead
- The centre leader was highly visible and worked alongside staff to address any immediate issues that challenged any department in the centre. To achieve this the centre leader held a daily morning huddle which was a structured and documented meeting aimed at resource and capacity planning. This included problem-solving any immediate issue, learning from incidents and complaints and key messages/ alerts for that day. We saw that the centre leader had total oversight of all the departments.

- Therewas a system of leadership development and succession planning for all members of the team. Staff at the centre told us they had been supported to attend courses and develop their skills. These courses ran over several months andcombined workshops, coaching and individual quality improvement projects.
- GenesisCare UK had also invested in training clinicians to evolve into frontline leaders in the NHS and private sector through aConsultant Leader Course.

**Vision and strategy**

**The centre had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.**

- GenesisCare UK had a vision to create great care experiences and to get the best possible life outcomes for patient, this was underpinned by four key values:
  - Empathy for all
  - Partnership for all
  - Innovation every day
  - Bravery to have a go
- To achieve this vision all GenesisCare UK centres had their own strategy which fitted in with GenesisCare UK overarching 'Service of the Future' (SOF). The SOF was an innovative,continuous development and improvement strategy which allowed centres to define best practice and adopt new innovations specific to their centres and monitor their strategy. SOF linked to work streams under three pillars; Quality, Access and Efficiency
- The SOF strategy was co-created following staff engagementacross the whole business, led by a designated SOF lead whose responsibilitywas to work with the centre leaders, drive the strategy and ensure engagement at all levels within the organisation. A face to face roadshow was run as an opportunity for every member of the GenesisCare Oxford team to feed into the patients' care pathway.
- A SOF UK snapshot poster summarised activity and achievements across the centres. This also highlighted new services and initiatives at GenesisCare UK.
- GenesisCare Oxford aimed to have 5 % of patients enrolled in clinical trials, 100% of patients to be offered surface guided radiation therapy (SGRT) and 100% of patients with prostrate cancer to be offered the free hydrogel implant.
- Senior centre leaders worked effectively within the cancer alliance radiotherapy network. The chief medical officer was a member of a local radiotherapy and breast advisory group. This was used to shape the breast service of the future (SOF) strategy.

**Culture**

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

- Managers across the centre promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staffwere proud of the organisation as a place to work and spoke highly of the culture and of their centre leader.
- Staff reported that the working atmosphere was friendly and supportive. Many training opportunities were available, often paid for or part paid for by GenesisCare, for staff who wanted to develop. However, there was no discrimination against staff who wished to continue working at the same level. Staff on the chemotherapy department told us they had been supported to attend courses and develop their skills.
- Staff were involved in the development of the Service of the Future (SOF) and were encouraged to sign up for inclusion into a work stream depending on an area of interest and/or expertise. Several projects were defined under eight work streams. Quarterly roadshows were held across the centres to provide progress updates with more regular communication in a monthly poster highlighting key activities that month, as well as a Team of the Month who were recognised for going above and beyond.
- Values postcards were distributed across all centres and staff were invited to send postcards to anyone they wish to recognise for living one or more of the values. Staff

could send in nominations for those colleagues they would like to put forward to be recognised as living one or more of the values, these were shared in a 'Feel Good Friday' communication to all staff.

- We were told this inclusive attitude for all members of the team had resulted in improvements in the recent staff engagement survey. Results nationally showed a 13% improvement up to 67%, and locally at Oxford with a 10% improvement to 57.5%.

**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.**

- GenesisCare UK aimed to have a clear and consistent governance process across all its centres. Monthly safety and quality committee meetings were held to cover corporate, clinical and information governance and benchmark against the other centres. Information was fed into these meetings from eight sub-committees, these were;
  - Medicines management committee
  - Infection prevention control committee
  - Radiation protection service committee
  - Resuscitation committee
  - Health and safety committee
  - Nursing advisory committee
  - Imaging service committee
  - Radiotherapy and technical committee
- Each subcommittee met either, monthly, quarterly or yearly and had an identified list of attendees, which included a lead and representation from each centre.
- Information was fed up from the safety committee to the GenesisCare UK leadership group and then up to the global executive leadership group. Centre leaders cascaded information to their teams by monthly team meetings or skype meetings. This forum was where centre leaders would update on issues and developments.
- GenesisCare UK had four clinical reference groups (CRGs) which provided medical and clinical leadership to the GenesisCare UK board in the areas of clinical protocol standardisation, research and innovation, clinical governance, and quality. The CRGs supported four service lines: radiotherapy, urology, breast and haematology. The groups met monthly via video conferencing andface-to-face on a quarterly basis.
- There was effective corporate oversight of performance regarding antimicrobial prescribing and stewardship. This was a discussed during the medicine's management committee meetings and documented in the minutes.
- Clinician's competence such as practising compliance with privileges and new consultants for review was monitored by a medical advisory board (MAC) and any issues were discussed during the monthly clinical leader's forum. This was chaired by the medical director. We reviewed the minutes for May 2019 and saw that whilst the MAC did not report monthly as a standardised agenda item a MAC update had been scheduled for the following month.

**Managing risks, issues and performance**

**Leaders 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.**

- GenesisCare UK had a consistent approach to managing and reporting on performance measures across all its centres. Performance dashboards were used for staff to discuss, benchmark and monitor performance at monthly senior management team meetings.
- Therewas a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviewed how they functioned and ensuredstaff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.

- GenesisCare UK had an in-date, version-controlled risk management policy which outlined identifying and determining risk, local and corporate risk registers and how compliance with the policy would be monitored.
- Staff at all levels were encouraged to raise risks to the local risk register which was reviewed and updated by the centre leader. Risks identified across the network were raised to the safety and quality committee and added to the corporate risk register, this was clearly set out in the risk management policy.
- We reviewed the centres risk register which contained local and corporate risks. All risks on the register had future review dates and we could see that regular and ongoing reviews were documented. Mitigation was in place for all the risks and it was clear the register was used as a live document.
- Risk assessments were in place for local activities and processes. We reviewed the risk assessment for the water bath in the radiology department. Potential risks of electric shock burn or infection had been identified, current controls were documented and the assessment was in date.
- Senior staff told us that GenesisCare UK were working towards standardising common risk assessments across all the UK sites.
- There was an in-date Oxford Business Continuity Plan, which identified what should be done in the case of a business or major incident, who the major incident team were, contact details of local utility companies and relevant private contractors.
- Staff in the chemotherapy department had access to the Oxford Chemotherapy Unit Business Plan, which identified short- and long-term actions if there were an increased demand on the service. Whist this was a controlled document, it was just due for renewal at the time of inspection.
- GenesisCare UK had identified that under its corporate social responsibility it needed a Brexit strategy. A working group had been set up and discussions had started to take place around potential issues such as medicines and radio-pharmaceutical access.

**Managing information**

**The service collected reliable data and analysed it. 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.**

- We were told the centre complied with General Data Protection Regulation (GDPR) and took into consideration Caldicott principles when making decisions on how data protection and sharing systems were designed and operated. Senior staff told us that GenesisCare UK have limited paper records and what paper is used was scanned into the electronic systems and the original destroyed.
- To reduce the need for clinicians removing hard copies of notes off site, all clinicians had access to remote clinical systems through individual double authentication logins on a web-based platform. We were told that passwords were managed centrally for security. However, some clinicians kept their own patient records and took responsibility for the storage and transportation of these records.They were registered independently with the ICO.
- There was an effective communication system. Staff showed us how they accessed meeting minutes and policies on the electronic platform and told us there were enough computers available.
- Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment in line with their roles and responsibilities. Staff had access to electronic nursing records which included detailed patient information such as patient medical histories, care plans, assessments and test results. Staff reviewed these through the electronic patient record system.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

- The services actively sought feedback from patients in writing or through conversations to improve the service

they provided. All patients completed a comprehensive questionnaire and information was collated onto a dashboard. The centre leader shared this with staff during monthly staff meetings.

- The centre awarded staff each month through an employee of the month initiative. All staff were encouraged to submit nominations for colleagues recognised to have practiced the centre's values. The centre collated and shared these in a 'feel good Friday' email to all staff. One staff member told us they had won store vouchers. Some staff said they felt recognised and valued through this initiative.
- Patients across all the departments completed satisfaction surveys and results were analysed, and actions taken. All patients who had finished their treatment were asked to complete a questionnaire and the information was collated onto a dashboard. Centre leaders shared this information with staff during monthly staff meetings. Leaders told us that free text commentary was shared as well and used to change practice, for example the range of snacks and drinks available in chemotherapy department were improved following feedback that the selection was limited.
- GenesisCare UK had involved all staff in the development of their vision and strategy. The recent staff engagement survey Results nationally showed a 13% improvement up to 67%, and locally at Oxford with a 10% improvement to 57.5%.
- Senior staff informed us they encouraged their teams to raise concerns though the online system, so the service could monitor themes and improve the service.

**Learning, continuous improvement and innovation**

- The corporate service improvement strategy, called 'Service of the Future' supported each centre's improvement goals and development projects to ensure a coordinated and multi-disciplinary approach was maintained.
- Genesis Care UK led on clinical projects and clinical trials with the aim of achieving the best outcomes for patients. These included areas such as pelvic radiotherapy and right breast radiotherapy using deep inspiration breath hold and surface guidance, a technique normally used for left breast cancers. The centre made sure patients who took part in clinical trials were followed up long-term by the clinical and research teams and they documented long-term results following strict clinical trial requirements.
- GenesisCare Oxford were working in partnership with an oncology research department at a local university to fund and build an MRI guided radiotherapy treatment machine. This technology integrates a radiotherapy and MRI machine which allows a more accurate delivery of radiation whilst the surrounding tissue is spared. Construction started in March 2019 with the aim of it being fully operational by the end of 2019.

Outstanding ☆

# Outpatients

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

## Are outpatients services safe?

Good

We rated outpatients as **good.**

**Mandatory training**

**The service provided mandatory training in key skills to all staff.**

- Staff accessed their mandatory training by a mixture of e-learning and practical sessions and received mandatory training in a variety of topics such as basic life support, conflict resolution, infection control, duty of candour and fire safety.
- At the time of our inspection the outpatient's department did not employ dedicated staff, though there were plans for this to change. One bank clinical nurse specialist worked in the breast care clinic and had completed all the required mandatory training.
- A health care assistant who worked in another department, would attend the clinic and assist the consultants by taking blood samples (venepuncture) and chaperone. At the time of our inspection all mandatory training requirements both practical and e-learning were up to date, alongside venepuncture and cannulation competencies.
- See information under this sub-heading in the medical care service section.

**Safeguarding**

**Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.**

- The service provided yearly safeguarding training as an online training package. Non-clinical staff received level one adult and children safeguarding training. This was up to date at the time of inspection.
- Staff who worked in the outpatient's departments were up to date with their training at the time of our inspection.
- Staff knew the centre leader was the lead for safeguarding and knew how to contact the corporate safeguarding lead trained to level four safeguarding adult and children. This met the intercollegiate guidance for safeguarding children.
- Staff knew where to access the centres safeguarding policies and had easy access to electronic versions on the provider's internal intranet. The policies were in date, version controlled and reflected national guidance.
- The staff we spoke with had not been involved in any safeguarding issues at the time of our inspection. However, all those staff we spoke with demonstrated an understanding of their safeguarding responsibilities and procedures, which included female genital mutilation (FGM) in the event of any concerns. This aligned with the service's safeguarding policies for adults and children.
- There were no safeguarding concerns reported to CQC over the last twelve months.
- See information under this sub-heading in the medical care service section.

# Outpatients

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

- Supplies of personal protective equipment (PPE), such as disposable gloves and aprons, were available in the department.
- Equipment in the outpatient department such as, trolleys and weighing scales were cleaned and a green 'I am clean' sticker attached.
- In the outpatient's department each consultation room and treatment room had a handwash sink with hand hygiene products and full paper towel dispensers mounted on the walls.
- Cleaning was completed daily when the rooms were in use, this was recoded and uploaded on to the shared drive. We saw all rooms had been cleaned for the weeks of 26 of August, the 2 September and the 9 September 2019.
- Staff, patients and visitors had access to wall mounted and portable hand sanitiser gel dispensers at the entrance to the centre, every department and relevant points throughout the department.
- The limited staff who worked in the department were up to date with infection control e-learning and practical requirements.
- There were five rooms used for outpatients' appointments. Four of which had wipeable flooring. One room had carpets, this was non-compliant with HBN note 00-09 Infection control in the built environment, (3.115 carpets) which stated that carpets should not be used in clinical areas. This included all areas where frequent spillage was anticipated, and spillage could occur in all clinical areas. To mitigate this risk a risk assessment had been completed with cleaning schedules and action plans in case of spillage and the clinic room was used for consultations only.

**Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.** Staff managed clinical waste well.

- The facilities, environment and equipment in the outpatients' department were well maintained. All the areas we visited were spacious, light, airy and clutter free.
- The clinic had an open-plan reception/ waiting area on the ground floor and reception staff always present.
- There were fire exit signage and fire extinguishers throughout the premises. All fire exits, and doors were kept clear and free from obstructions. The centre tested fire alarms weekly.
- Emergency trolleys, which included resuscitation equipment, were available on each level. The trolleys were tamper-evident to reduce the risk of equipment being removed and not available in an emergency. Staff carried out daily and weekly checks of this equipment to ensure it was ready for use in an emergency. We checked the trolley in the outpatient's departments which was checked in line with policy, no dates had been missed for the month so far. We saw information was located with or above the trolleys, providing guidance for staff about the emergency procedures and action to take, such as sepsis.
- Stickers on equipment and machinery identified the last service date and when the next service was due. We examined two items of equipment which had been serviced or maintained within the last 12 months.
- In cleaning storage areas, staff had ensured consumables, were stored off the floor in line with national guidance.
- In all areas we inspected staff complied with the Department of Health, Health Technical Memorandum 07/01, safe management of healthcare waste (2013). All waste was segregated in different coloured bags and posters were displayed explaining which item went into which waste stream. GenesisCare UK had a waste management standard operating policy which outlined to staff the processes and procedures to be followed to ensure compliance.

- Containers were provided for the safe disposal of sharp equipment, such as needles and cannulas. We observed these were labelled correctly on assembly and when ready for collection. None of the containers were overfilled, reducing the potential of needle stick injury.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient and removed or minimised risks. However, the service did not follow NHS England national Safety Standards for Invasive Procedures (NatSSIPs).**

- The service had comprehensive standards operating procedures for running specific outpatients' clinics and we reviewed the gynaecology SOP. This comprehensive SOP identified the process for completing specific procedures and this included colposcopy and biopsy removal which were invasive procedures. The SOP identified three step identification and how biopsies should be taken.
- The clinic used an outpatient procedure record which included a localised World Health Organisational (WHO) surgical safety checklist. This was in line with NHS England National Safety Standards for Invasive Procedures (NatSSIPs). NatSSIPs were published in 2015, procedure record included pre-procedure checks, a procedure sign in, a record of medicines given, number of sharps and swabs opened and used, the number of and type of specimens taken and post procedure checks.
- At the time our inspection the service did not audit their performance of the WHO checklist.

**Nurse staffing**

**The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**

- We attended the daily huddle which was co-ordinated by the centre manager and attended by all staff. During this meeting staffing for all departments was discussed and any issues identified.
- At the time of our inspection the service did not employ staff specifically in the outpatient's department, however the centre leader told us that the service requirements were changing and this would require the recruitment of an outpatients lead.
- The outpatient department accessed the centres health care support worker and a bank breast care Clinical Nurse Specialist (CNS) to provide chaperoning and attend the breast clinic.

**Medical staffing**

See information under this sub-heading in the medical care service section.

**Records**

- For those times when paper records were used for example in outpatients and medicines administration all records were scanned and uploaded to the electronic system and then shredded once completed.
- There were no patients in the outpatients' department at the time of our inspection. Please see the medicines section of this report for information on records.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

- Medications were stored safely. Medications were kept in temperature-controlled fridges and monitored daily. The dispensary had air conditioning which allowed the ambient room temperature to remain at a consistent level.
- Staff managed outpatient prescription pads safely in locked cupboards.

**Incidents**

**The service managed patient safety incidents well. Staff recognised incidents and reported them safely. 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.**

# Outpatients

- Staff showed a good understanding of incident reporting and told us how they would raise an incident using the electronic reporting system. All staff we spoke with confirmed the service encouraged staff to report all incidents.
- There were two incidents reported relating to the outpatient's clinics during the reporting period, June 2018 to May 2019. Both incidents were minor and we reviewed the incident reports and saw actions had been put in place and fully approved.

## Are outpatients services effective?

Not sufficient evidence to rate

We inspected but did not rate effective in this service as we do not collect sufficient information to make a judgement.

**Evidence-based care and treatment**

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.**

- The service used a range of evidence-based guidance, legislation, policies and procedures to deliver care, treatment and support to patients.
- Staff had access to policies and operating procedures through an online system. We reviewed a standard operating procedure (SOP) for the running of the Outpatient Gynaecological Clinic. Which was comprehensive, in-date and version controlled. this SOP identified step by step how the clinic room must be set up, that aseptic technique must always be used where appropriate, a chaperone must be present, the consent procedure and that a three-point identification check to be completed and documented in the notes. The SOP identified the procedure for labelling and sending off biopsies.
- See information under this sub-heading in the medical care service section.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs.**

- Staff told us that patients were not generally offered food for a clinic consultation; however, the centre outpatients waiting area had a drinks machine, biscuits and water for patients and their carers/ relatives attending the department.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain.**

- The service did not generally provide pain relief to patients who attended outpatients' consultations, however would make referrals to a patients GP should this be required.

**Patient outcomes**

- See information under this sub-heading in the medical care service section.

**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.**

- The leaders ensured that the clinical nurse specialist who worked as a bank nurse in the outpatient's department was competent for the role. Regular one to one and appraisals were completed, and chemotherapy practice competencies had been fully completed and signed off.
- The health care assistant had completed eight hours clinical practice development to ensure competence in venepuncture and cannulation and had received monthly one to ones and yearly appraisals.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

- See information under this sub-heading in the medical care service section.

**Seven-day services**

- The centre did not provide overnight beds and opened from Monday to Friday from 8am to 5pm. Outside these hours, the centre provided a 24-hour nurse led triage line to support cancer patients

Outstanding ☆

# Outpatients

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

- Health promotion leaflets were displayed in relevant areas throughout the centre these included healthy eating and advice on stopping smoking.

**Consent and Mental Capacity Act**

**Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.**

- Staff understood their roles and responsibilities the Mental Capacity Act 2005. At the time of our inspection all staff had completed the centres consent and mental capacity and deprivation of liberty safeguard mandatory training.

## Are outpatients services caring?

Not sufficient evidence to rate

We did not see any examples of caring as there were no patients in the department during our inspection. Therefore, we have been unable to rate this key question.

**Compassionate care**

- See information under this sub-heading in the medical care service section.

**Emotional support**

- See information under this sub-heading in the medical care service section.

**Understanding and involvement of patients and those close to them**

- See information under this sub-heading in the medical care service section.

## Are outpatients services responsive?

Good

We rated responsive as **good.**

**Service delivery to meet the needs of local people**

**The service planned and provided care in a way that met the needs of local population. It also worked with others in the wider system and local organisations to plan care.**

- The services provided reflected the needs of the population and ensured flexibility, choice and continuity of care. The service provided patients planned appointments for consultations and scans at their convenience through the choice of appointment days and times to suit their needs.

- See information under this sub-heading in the medical care service section.

**Meeting people's individual needs**

**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.**

- See information under this sub-heading in the medical care service section.

**Access and flow**

**People could access the service when they needed it and received the right care promptly.**

- See information under this sub-heading in the medical care service section.

**Learning from complaints and concerns**

**It was easy for people to give feedback and raise concerns about care received.**

- There had been no complaints attributed to this core service at the time of our inspection.

- See information under this sub-heading in the medical care service section.

## Are outpatients services well-led?

Outstanding ☆

We rated well led as **outstanding.**

**Leadership**

# Outpatients

**Leaders had the integrity, 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. comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.**

- The outpatient department was consultant led and managed by the centre leader. At the time of our inspection the outpatient's department accessed the services of one clinical nurse specialist for breast clinics and the centres health care support worker for chaperoning duties. The service was in the process of employing further staff as the service grew.

- See information under this sub-heading in the medical care service section.

**Vision and strategy**

**The centre had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.**

- See information under this sub-heading in the medical care service section.

**Culture**

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

- Staff received training in the duty of candour at the time of our inspection, staff who worked in outpatients had completed duty of candour mandatory training.
- See information under this sub-heading in the medical care service section.

**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.**

- See information under this sub-heading in the medical care service section.

**Managing risks, issues and performance**

**Leaders 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.**

- See information under this sub-heading in the medical care service section.

**Managing information**

**The service collected reliable data and analysed it. 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.**

- See information under this sub-heading in the medical care service section.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

- See information under this sub-heading in the medical care service section.

**Learning, continuous improvement and innovation**

**All staff were 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 participation in research.**

- See information under this sub-heading in the medical care service section.

Good

# Diagnostic imaging

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

## Are diagnostic imaging services safe?

Good

We rated safe as **good.**

**Mandatory training**

**The service provided mandatory training in key skills to all staff however not everyone had completed it.**

- Mandatory training was delivered by a mixture of e-learning and practical sessions. However, not all staff in the department had completed their training requirements. One member of staff had six out of the 13 elements of e-learning expired and another staff member had three out of the five required practical elements with no date having ever been completed.
- Staff had read the local radiation protection rules (local rules) and understood their roles and responsibilities.Local rules were in-date, displayed and all appropriate staff had signed to say they had read them. Staff told us they had received relevant training on radiation risks.

- See information under this sub-heading in the medical care service section.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**

- All the staff in the PET-CT and MRI department had completed level 2, adult and child safeguarding mandatory training.
- Staff we spoke with knew the escalation process should they need to report a safeguarding concern and would contact the safeguarding lead at the centre with any queries or concerns.

- See information under this sub-heading in the medical care service section.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

- The CT and MRI departments were all visibly clean and tidy. We reviewed the cleaning rota in the MRI and the PET-CT suite and all areas were checked and cleaned every day and in-between patients. Green 'I am clean stickers' were placed on machines to show when and by whom they had been cleaned.
- Supplies of personal protective equipment (PPE), such as disposable gloves and aprons, were available in each department. We observed all staff used the correct PPE when providing care and treatment to patients.
- Patients received healthcare from staff who decontaminated their hands immediately before and after every episode of direct contact or care, this was in line with NICE QS61 Infection prevention and control statement 3.

Good

# Diagnostic imaging

- See information under this sub-heading in the medical care service section.

**Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

- The centre offered diagnostic services with the use of the following equipment;
  - One dual purpose computed tomography(CT) and positron emission tomography–computed tomography(PET-CT) scanner.
  - One 3T magnetic resonance imaging (MRI) scanner.
- The reception area was visibly clean, light and airy with comfortable looking chairs and sofas. A drinks machine was available offering free hot and cold drinks for patients and visitors.
- Patients would wait in the reception area prior to being called to the appropriate department. The main clinic had an open-plan reception/ waiting area on the ground floor and reception staff were always present. Access to the MRI and PET-CT was restricted.
- The PET-CT was housed in a separate building, which had a reception area and reception staff were always present. Although smaller than the main clinic the space was light and airy and visibly clean. Access to the scanning area was restricted.
- A resuscitation/ emergency trolley was available in the building. The trolley was tamper-evident to reduce the risk of equipment being removed and not available in an emergency. Staff carried out daily and weekly checks of this equipment to ensure it was ready for use in an emergency. The trolley had been checked in line with policy, no dates had been missed for the month so far. We saw information was located with or above the trolleys, providing guidance for staff about the emergency procedures and action to take, such as sepsis.
- The PET-CT scanning room was set up to be patient friendly and had mood lighting and if patients wanted could listen to music and watch digital images to help reduce anxiety, such as the northern lights.
- The PET-CT was installed in April 2019. We reviewed the handover reports which were all approved. The next service was booked for April 2020.
- We reviewed the 3T MRI service documents, the last service had been completed in July 2019 and no problems had been identified. The next service was booked for May 2020.
- In the event any of the machines would fail these checks there were numbers to contact for the nuclear medical physics departments or the suppliers. There had been one breakdown, in the PET-CT, which was fully recorded and dealt with remotely, no patient time was lost. There had been two breakdowns in the 3T MRI, no lists were affected.
- Quality assurance processes were completed daily by the lead of the departments and recorded electronically and quarterly by medical physics team. External engineers were planned to visit twice a year for preventative checks, we saw the first appointment for the PET CT suite was in September 2019.
- The PET-CT quality assurance checks included helium levels, oxygen level, chiller temperature, the MRI included scanner and coil checks. We reviewed the checks for the month of July for both the PET-CT, and the MRI, and all were completed and recorded as passed.
- We reviewed the environmental agency permit for the PET-CT suite and saw this was in date and there had been no breaches during the last inspection in April 2019.
- The PET-CT suite had a monitoring process/waste log which ensured only those sharps bins that contained decayed radioactive waste and cannulas were removed for disposal by a licensed company authorized for the removal of radioactive/isotope material/remnants.
- The PET-CT unit had a spillage policy which was in date. The unit had a spillage kit, which was audited/ checked monthly. Staff told us how they would manage a spillage but to date there had never been one.
- We saw evidence that film badges and rings were worn. A film badge is a dosimeter used for monitoring cumulative radiation dose.

Good

# Diagnostic imaging

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

- As required by the Health and Safety Executive (HSE) who regulate the Ionising Radiations Regulations 2017 (IRR99), all areas where medical radiation was used were required to have written and displayed local rules which set out a framework of work instructions for staff. These local rules were displayed throughout the department.

- The service had the support of an external radiation protection advisor (RPA) and an onsite radiation protection supervisor (RPS). There was also an on-site lead physicist who helped develop protocols, check the quality assurances processes on all the equipment and was part of the team developing the protocols and governance for the new MRI which was being built during the time of our inspection. The MRI had a nominated safety lead who would cascade any safety updates to the relevant staff.
- The PET-CT had adapted the relevant local rules in line with Regulation 17 of the Ionising Radiations Regulations 2017. In the PET-CT suite there were local rules displayed in the Hot Toilet where the radioactive waste would be excreted. All relevant staff had read and signed the local rules policy, which applied to all persons who could be exposed to ionising radiations.
  - In line with the National Institute of Health and Care Excellence (NICE) Acute kidney injury guidelines and the Royal College of Radiologists standards for intravascular contrast agent administration patients were assessed to ensure they could receive contrast. A screening process performed by the radiographers enabled them to identify any pre-existing clinical conditions which could impact on the ability to perform scans with contrast. Contrast media is a substance used to increase the contrast of structures or fluids within the body and is used in certain types of radiological investigations.

  - Staff asked patients about their allergies as part of the routine checks prior to administering any contrast. This was in line with national guidelines. Any allergies were documented on patient referral forms.

- There were procedures in place for the collapse of a patient in the MRI and these were practiced. The latest scenario practiced was in June 2019, staff reported to us that this had been a successful practice.

- All patients completed a pre-MRI safety checklist which included questions such as if they had a cardiac pacemaker or metal fragments in their eye or their body. Certain metal fragments and pace makers could cause the magnets in the scanner to malfunction.

- Patients were given a precaution sheet following PET-CT scanning which detailed the dose of radioactive material they received for their scan and what precautions to take afterwards to minimise any potential contamination risk to other people. This information was discussed with the patient when the scan was booked, before the scan when the patient was in the department and a paper copy given to the patient when they left.

- Staff who had not received radio-protection training, were not allowed into the suite. In case of an emergency, the daily huddle identified who would be allocated to which area. This ensured there was no confusion should an emergency.

- There were processes in place to ensure the right person received the right scan at the right time. Staff completed a six-point check of name, date of birth, address, body part, clinical information and previous imaging checks in line with the legal requirements of IR(ME)R to safeguard patients against experiencing the wrong investigations.

- There were posters and signs which informed patients who were, or who could be pregnant, to let a member of staff know. This was included in the CT safety questionnaire sheet and again at the consent stage. These were scanned into the patient record and then shredded.

- There were protocols for the PET-CT and MRI, all were in date, version controlled, all of which would be reviewed yearly. All protocols were reviewed by the local RPS, the lead radiologist and the external RDA.

- There were risk assessments in line with the application of the Ionising Radiations Regulations 2017. We reviewed a risk assessment for fasting

diabetic patients, who were at an increased risk of low blood sugar. The risk assessment outlined what procedures to take to minimise to risk of this happening and what to do should an incident occur.

- Diagnostic Reference Levels (DRL's) for standard radiological examinations were used by GenesisCare UK as an aid to optimisation. As in the case for the new PET-CT the local DRL's had not yet been set as data was being gathered and audited. In the interim, the relevant level was based on national or European data. Whilst these were not displayed at the time of our inspection the staff were very knowledgeable aboutthe appropriate dose for examinations. The relevant levels were detailed in the radiation protection policy.

**Radiology staffing**

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

- Staff told us there were enough staff to safely run the service and although the service wanted to grow and expand it would not do so until adequate staffing ratios were in place. At the time of our inspection, the service employed;
  - MRI- one whole time equivalent (WTE) lead radiographer.
  - PET-CT- one WTE lead radiographer.
  - PET-CT- one whole time equivalent (WTE) senior radiographer.
- The centre lead told us they were also in the process of recruiting a further MRI radiographer.
- We attended the daily huddle which was co-ordinated by the centre manager and attended by all staff. During this meeting staffing for all departments was discussed and any issues identified.
- Weekly operational calls with the Director of operations, Centre leaders and function leads support any additional requirements or changes in planned activity, during these calls staffing would be discussed and if necessary staff would come from other centres to work.
- Staff would work across sites if the need arose.

**Medical staffing**

- The RMO was booked to attend the department during treatment days when, radio-isotopes and CT contrast were in use.
- For further details, see information under this sub-heading in the medicines' service section.

**Records**

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

- Staff managed patient care records in a way that protected patients from avoidable harm. Electronic records were available through the centre's computer system and were only accessible by authorised staff with a secure password.
- Radiologists had remote reporting facilities to allow for diagnostic imaging reporting. Whilst IT support was largely provided in-line with working hours, arrangements could be made for support out of hours when required.
- Staff updated the electronic records after they had completed a scan and submitted the scan images for reporting. Any paper records, such as consent, and checklists were scanned into the system and then the paper records were shredded.
- The service used secure imaging and archiving system with password protection. Each staff member had their own personal identifiable password to access the system. We saw all staff logged out the system after use.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

- The service stored, handled and disposed of contrast media (substance used to increase the contrast of structures or fluids within the body in medical imaging) in line with national guidance.
- We checked CT contrast and saw it was in date stored correctly in a warming cabinet, the temperature of the warming cabinet was recorded daily.

Good

# Diagnostic imaging

- The provider provided nuclear medicine treatment. This branch of medicine deals with the use of radioactive substances in research, diagnosis, and treatment. There were two nuclear medicine consultants who delivered services at the centre and both held an in date Administration of Radioactive Substances Advisory Committee (ARSAC) practitioners licence.
- For further details, see information under this sub-heading in the medicines' service section.

**Incidents**

**The service managed patient safety incidents well. Staff recognised incidents and reported them safely. 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.**

- GenesisCare UK had an in-date, version-controlled incident, accident and near miss policy which staff accessed electronically.
- Staff showed a good understanding of what incidents should be reported and how they would raise an incident using the electronic reporting system. All staff we spoke with confirmed the service encouraged staff to report all incidents.
- The PET-CT was a relatively new department and had been installed in April 2019. Staff reported that with exception of the one incident of the machine breakdown, there had beenno incidents since the service started.
- Staff in the PET-CT and MRI told us they felt supported and encouraged to report any incidents that may occur.
- There was one incident in the MRI suite which did not require reporting to the CQC, the Health and Safety Executive or IRMER. This incident involved contrast not given when requested. We reviewed the root cause analysis report for the near miss, this clearly identified what the issue was, how it occurred and how to ensure this was not repeated.

## Are diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effective in this service as we do not collect sufficient information to make a judgement. However, we found the following areas of good practice:

**Evidence-based care and treatment**

**The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**

- The service used a range of evidence-based guidance, legislation, policies and procedures to deliver care, treatment and support to patients. We saw care pathways followed nationally recognised recommendations such as the National Institute for Health and Care Excellence (NICE) guidance. diagnostic scans were based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and Royal College of Radiologists (RCR) guidance. The provider's policies and procedures were subject to review by the radiation protection advisor, and the medical physics expert, in line with IR(ME)R 2017 requirements.
- Staff had access to policies and guidelines through an online system. All the guidelines we reviewed were easily accessible through an online system and were up to date.
- Peer reviewed clinical protocols were available for diagnostic tests. Any trials and cases which fell outside clinical protocols were referred to the clinical advisory team. The team held virtual peer review meetings in collaboration with clinicians to discuss the evidence behind protocol deviations. The final decision was documented in patients' electronic medical record.
- We saw staff had access to diagnostic reference levels that covered all the basic examinations performed. The local DRL's had not yet been set as data was being gathered and audited. In the interim, the relevant level was based on national or European data.

Good

# Diagnostic imaging

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs.**

- Drinks were available for all patients and relatives visiting the MRI and PET-CT departments.
- There were in date risk assessments in line with the application of the Ionising Radiations Regulations 2017. These risk assessments covered care of a fasting diabetic patients.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain.**

- Staff asked patients during their scanning appointment if they were comfortable
- See information under this sub-heading in the medical care service section.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment.**

- The centre had an audit programme to identify, monitor and drive quality improvement. The audit schedule included control of radioactive sources. This was a six-monthly audit and the centre scored 100% in April 2019.
- Staff in the MRI suite told us that they audited reporting times. The target was 24-48 hours the centre also monitored radiologist's turnaround reporting times over the last 12 months these had been PET-CT, 28 hours, MRI- 21.3 hours and CT- 20.7 hours. This meant referrers had timely access to reports and made sure patients received timely care.
- The PET-CT suite opened in April 2019 and was in the process of auditing their diagnostic reference levels (DRL) to ensure they aligned to national DRLs.
- The centre had just started to review image quality monthly of PET-CT and CT scans, in line with policy 10% were checked by head office, however staff told us they also held regular peer reviews in house to check their quality and performance.
- The centre held monthly oncology and diagnostic staff meetings. This meeting followed a standardised agenda and was broken down into two parts. Part one was non-governance and Part 2 was governance an audit. We reviewed the minutes for May 2019 meeting and saw an action from the previous meeting to review and localise the IRMER policy had been completed and closed.

**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.**

- In addition to mandatory training, staff completed competencies for all modality of scans provided at the centre. Staff told us they had good support for their development and training. Staff could access training the centre provided, as well as training and development by external companies if required.
- Peer reviews were completed by in house staff in the MRI and PET-CT departments.
- All members of the department had a recent appraisal by the centre leader. Staff told us whilst the did not receive protected clinical practice development time (CPD), they were fully supported to expand their practice and attend external courses.

**Multidisciplinary working**

**Radiographers and radiologists and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

- See information under this sub-heading in the medical care service section.

**Seven-day services**

- See information under this sub-heading in the medical care service section.

**Health promotion**

- See information under this sub-heading in the medical care service section.

**Consent and Mental Capacity Act**

Good

# Diagnostic imaging

**Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.**

- Consent was a two-stage process and was checked again when the patient came for any form of investigation or treatment, this was signed by the patient and radiographer, scanned and uploaded to the electronic system.
- Patient consent, Mental Capacity ACT and Deprivation of Liberty Safeguarding mandatory training (practical) had been completed by all members of the department.
- See information under this sub-heading in the medical care service section.

## Are diagnostic imaging services caring?

Good

We rated caring as **good.**

**Compassionate care**

**Staff truly respected and cared for patients with compassion. Feedback from patients continually confirmed that staff treated them well and with kindness.**

- We observed all patients were treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty in line with NICE QS15 Statement Patient experience in adult NHS services 1. Interactions between staff, patients and visitors were respectful and considerate. We observed that all staff introduced themselves to their patients in line with NICE QS15 Statement 3.
- The MRI and PET-CT centres was designed to ensure that people's privacy and dignity needs were understood and always respected. All staff-maintained privacy, with closed doors and clear signage indicating the room was occupied.
- The centre had designated quiet rooms where staff, patients and their relatives could have private conversations or wait for treatments away from the waiting areas.
- Patients could have a chaperone and there were posters and laminated leaflets displayed across all the departments informing patients about their availability. There was an in-date chaperone policy available on the intranet.

**Emotional support**

**Staff continually provided emotional support to patients to minimise their distress. Staff we spoke with valued patient's emotional and social needs. Staff embedded these in their care and treatment.**

- Patients told us they were satisfied with the verbal and documented information staff provided them.
- Throughout all the patient and relative interactions, we observed how staff understood the impact a person's care, treatment or condition could have on their wellbeing, both emotionally and socially. Patients emotional and social needs were seen just as important as their physical needs.
- See information under this sub-heading in the medical care service section.

**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.**

- The diagnostic team met the patients and their relatives and showed them round the department. This allowed them to identify any issues which could affect their treatment such as mobility issues.
- See information under this sub-heading in the medical care service section.

## Are diagnostic imaging services responsive?

Good

We rated responsive as **good.**

**Service delivery to meet the needs of local people**

**The service planned and provided services in a way that met the needs of local people.**

Good

# Diagnostic imaging

- The centre was open from 8am to 5pm Monday to Friday. Scans were booked in discussion with patients to ensure times were convenient for both the radiologist and the patient.
- The environment in the department was comfortable, there was enough seating, plenty of toilet facilities, and drinks machines available for patients and relatives.
- See information under this sub-heading in the medical care service section.

**Meeting people's individual needs**

**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.

- The diagnostic team met the patients and showed them round the department. This allowed them to identify any issues which could affect their treatment such as mobility issues.
- Staff told us that relationship with consultants worked well, even when they were off site. All consultants could be contacted if any patient problems required escalating.
- There were quiet areas in all departments where sensitive conversations could be carried out.
- See information under this sub-heading in the medical care service section.

**Access and flow**

**People could access the service when they needed it and received the right care promptly.**

- The centre provided a rapid diagnostic and assessment service and followed pathways, in line with the national cancer strategy.
- The centre leaders monitored but did not audit the time patients waited for their appointment once they arrived in the department. From June to end of August 2019 the dashboard showed that overall 70% and above of patients waited less than five minutes for their appointments.
- The centre leaders monitored radiologists reporting times and aimed for a turnaround time of 24-48 hours. Over the last 12 months these had been PET-CT, 28 hours, MRI- 21.3 hours and CT- 20.7 hours.
- The centre lead told us they would see those patients with the potential of spinal cord compression within 24 hours. This was in line with NICE guidelines (QS56) and centre policy. Metastatic spinal cord compression (MSCC) is a complication of cancer and is a clinical oncology emergency which requires prompt diagnosis and urgent treatment to prevent or reduce the risk of paraplegia.
- If there were any problems with the machines at the centre, staff would arrange an appointment at another clinic, and provide a taxi to transport the patient.

**Learning from complaints and concerns**

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**

- See information under this sub-heading in the outpatients' service section

## Are diagnostic imaging services well-led?

Outstanding ☆

We rated well led as **outstanding.**

**Leadership**

**Leaders had the integrity, 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.**

- The centre had a clear accountability and leadership structure. Managers at all levels had the right skills and abilities to run the service providing high-quality sustainable care. Staff told us that the centre lead was highly visible and worked alongside staff to deliver safe and effective care.

Good

# Diagnostic imaging

- The lead MRI and PET-CT staff reported to the centre leader. The centre leader reported to the Director of Operations who sat within the GenesisCare UK Leadership Team.
- The centre leader understood the challenges to quality and sustainability. The centre leader told us to grow their own service they had built expanded into another building with the fully functional PET-CT/CT service.

**Vision and strategy**

**The centre had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.**

- See information under this sub-heading in the medical care service section.

**Culture**

**Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

- See information under this sub-heading in the medical care service section.

**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.**

- Lead radiographers from both diagnostics and the radiotherapy department attended the monthly safety and quality committee meeting.
- See information under this sub-heading in the medical care service section.

**Managing risks, issues and performance**

**Leaders 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.**

- We reviewed the local risk register which had clinical, operational, environmental and moving and handling risks identified. Each risk was clearly identified as being reviewed or approved and was rated as low or medium.
- The service had business continuity plans and risk assessments to support sudden IT failures and power outages. Whilst the centre did not have a back up generator for the PET CT or the MRI, the business continuity plan identified other centres that would be used in the case of power failure.
- Staff we spoke with understood their responsibilities under IR(ME)R and they followed the provider's procedures.
- See information under this sub-heading in the medical care service section.

**Managing information**

**The service collected reliable data and analysed it. 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.**

- See information under this sub-heading in the medical care service section.

**Engagement**

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

- See information under this sub-heading in the medical care service section.

**Learning, continuous improvement and innovation**

Good

# Diagnostic imaging

**All staff were 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 participation in research.**

- The corporate service improvement strategy, called 'Service of the Future' support each centre's improvement goals and development projects to ensure a coordinated and multi-disciplinary approach was maintained.
- The centre had recently gone live with offering functional MRI scans. This works by detecting the changes in blood oxygenation and flow that occur in response to neural activity – when a brain area is more active it consumes more oxygen and to meet this increased demand blood flow increases to the active area. The main advantage of functional MRI is there is minimal risk to the patient as it does not use radiation like X-rays, computed tomography (CT) and positron emission tomography (PET) scans. It can evaluate brain function safely, non-invasively and effectively.

# Outstanding practice and areas for improvement

## Outstanding practice

The pharmacy staff had recognised the complex nature of some of the treatment regimens prescribed at the centre. A colour coded, patient specific, medicine calendar was designed by the team which plotted what medicine should be taken and when.

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should ensure that all staff complete their mandatory training.
- The provider should consider the removal of all carpets in clinical areas.
- The provider should consider a more standardised format for medical advisory meeting.
- The provider should audit their performance of the surgical safety checklist.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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