Genesis Cancer Care UK Limited

Genesis Care, Milton Keynes

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

This was the first rated inspection for Genesis Care Milton Keynes. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. 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 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.
- The service planned care to meet the needs of the people who used it, 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 too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. 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. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Some fire safety requirements were not adhered to.
- Some policies were unclear and contradictory.

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)	Good 	GenesisCare Milton Keyes is operated by Genesis Cancer Care UK Limited. The centre provides diagnosis and treatment to patients over 18 years old. The service offers both chemotherapy and radiotherapy treatments in a modern purpose-built facility. There is a wellbeing centre and an exercise clinic. There are no overnight beds. We inspected this service using our comprehensive inspection methodology and using our cancer framework. We carried out an unannounced inspection on 9 February 2021. 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. The main service provided by this hospital was oncology.

Summary of findings

Contents

Summary of this inspection

Background to Genesis Care, Milton Keynes

Genesis Care Milton Keynes is an independent provider of cancer services and is one of fourteen locations across the country. It offers chemotherapy, radiotherapy and the associated diagnostic and outpatient services to local patients and to those from abroad.

The service is operated from a modern, standalone building which is not shared with any other healthcare provider. The unit was open from 8am until 8pm each weekday although therapies only took place from 8:30am until 5pm.

Genesis Care Milton Keynes has a registered manager in position who has been in post for two years.

The regulated activities are:

- Treatment of disease, disorder or injury
- Family planning
- Diagnostics and screening.

The main service provided by the centre was cancer care. We have inspected and reported all cancer care services under the CQC Cancer Assessment Framework.

How we carried out this inspection

We carried out an unannounced, responsive, comprehensive inspection at this location following actions taken in response to concerns raised in 2020.

The team that carried out this inspection comprised a CQC lead inspector, a second CQC inspector and a specialist advisor with expertise in radiotherapy. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

We visited all parts of the clinic and spoke to staff from all areas of the service. We reviewed four sets of patient notes and observed care and treatment.

We spoke to four patients and two relatives about their experiences in the clinic.

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

Outstanding practice

We found the following outstanding practice:

- The provider had introduced Surface Guidance Radiotherapy Treatment (SGRT). This technology allows radiation to be targeted from direct surface measurement without the need for skin marking, and when used in conjunction with Deep Inspiration Breath Holding (DIBH) better reduces the radiation dose to the heart.

Summary of this inspection

- The provider had introduced “smart” infusion devices for the delivery of chemotherapy drugs which were integrated with a computer network. These types of system can reduce errors through the use of drug and protocol libraries and communication with electronic prescribing and electronic patient record systems.
- The service provided patients with taxi transfers from home to the centre, for the treatment so, patients and those close to them did not have to worry about how they would get to the centre.

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that staff understand the risks associated with obstructing fire doors and not wedge them open.
- The provider should consider reviewing the pregnancy policy to make clear how the phrase, "if greater accuracy required to undertake a blood test" is to be interpreted.
- The provider should review the consent policy to ensure that it accurately reflects expectations and practice and complies with the equality act.

Our findings

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	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care (Including older people's care)

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

Are Medical care (Including older people's care) safe?

Good

We rated it as good because:

Mandatory Training

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

Staff received and kept up to date with their mandatory training.

All staff received comprehensive and suitable mandatory training according to a matrix which specified the training needs of each member of staff's job profile. Training was provided either on-line, face-to-face or through practical sessions. We noted that a training module for staff in safe working from home formed part of the training for all staff demonstrating that the mandatory training system responded to changing circumstances.

Managers monitored mandatory training and alerted staff when they needed to update their training. This was readily achieved through colour coded reports that identified staff who were coming up for, or who had missed their training anniversary.

We reviewed the mandatory training compliance for the location and noted that it was high. For most requirements 100% of staff were up to date and for the others it was over 90%. One exception was moving and handling training for which the e-learning was 96% but the practical training was very low at 63%. This appeared to be company-wide issue due to COVID-19 restrictions and represented a conscious risk decision rather than an omission.

When we carried out our inspection this was raised by the registered manager and they told us that they had now arranged a safe and effective way of training staff under the restrictions of Covid-19. 14 staff had received their practical manual handling training the previous week and that everyone else would receive it in the coming weeks.

Safeguarding

Good

Medical care (Including older people's care)

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 staff were trained to safeguarding adults level one and all clinical staff were trained to safeguarding adults level two. Similarly, although no children were treated at the clinic, all staff had safeguarding children level one training and all clinical staff were trained to safeguarding children level 2. Yearly updates to safeguarding training were mandatory and the clinics compliance rate was 100%.

We asked for the most recent example of when a safeguarding referral had been made. We were told that a patient had disclosed that they were a victim of domestic violence and staff knew that there were children in the home.

All staff had Disclosure and Baring Service (DBS) checks prior to appointment.

Staff were knowledgeable and confident about safeguarding despite it being infrequently needed.

There was a named safeguarding lead for the organisation. Staff who we spoke to were aware of who it was, and contact details were displayed on posters. However, some of these were out of date and had the wrong name. When we pointed this out, they were removed from the notice boards. The registered manager was trained to children's safeguarding level three and their contact details were easily available.

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 clinic was located in a modern, spacious and airy building. Furnishings were suitable and would be easy to keep clean. Although some areas had carpet this was confined to areas where treatment would not take place.

All areas of the building were visibly clean and tidy to a very high standard. Staff wore suitable clothing or uniform and adhered to basic infection prevention standards such as having long hair tied back and being bare below the elbows when dealing with patients.

There was a named local Infection Prevention and Control lead.

There was a suitable and up to date infection prevention and control policy which staff were familiar with. This policy in turn referenced some 20 other policies ranging from the control of legionella, through to cough etiquette.

Staff had received suitable training and were seen to be following their procedures for the safe and effective use of PPE and infection control techniques including the washing of hands. Staff wore suitable uniforms and were bare below the elbow. There were plenty of handwashing facilities and gel dispensers throughout the building.

Staff received mandatory training every year on the prevention of healthcare associated infection as well as more general infection prevention and control training. Additional training in the management of IPC in a pandemic had also been introduced. Local compliance rates for this training were at or very nearly 100% for all these modules.

There were posters about use of PPE including, for example, when to use level 3 Filtering FacePiece (FFP3) masks and how to don and doff correctly.

Good

Medical care (Including older people's care)

PPE was available throughout the building, suitable and in plentiful supply. The registered manager told us that PPE was provided centrally and that they had never run out.

All equipment and treatment rooms were cleaned between patients and equipment was labelled as having been cleaned which is good practice. There was enhanced cleaning for some equipment such as cystoscopes.

Additional cleaning had been introduced to ensure surfaces and touchpoints were wiped down at additional times during the day. Cleaning was carried out against schedules, specifications and in the case of the radiotherapy suite a standard operating procedure. Schedules were completed to indicate that the tasks had been completed and regular audits and spot checks took place. These indicated high compliance with the requirements.

The staff room had been risk assessed for six people to occupy it at the same time and there was an arrangement for staff to stagger their breaks to minimise occupancy. We noted that there were more than six seats in the staff room which might encourage staff to occupy seats closer than was safe. We drew this to the attention of the registered manager who took steps to address the issue.

There was a protocol for ensuring that patients attending for treatment were screened for infection by COVID-19 . Patients had their temperature taken and were asked about relevant symptoms every time they attended the clinic. All patients received a Polymerase Chain Reaction (PCR) COVID-19 test weekly.

There was a protocol in place so that COVID-19 patients could be treated in isolation with enhanced infection control procedures. As, at the time of the inspection, no patients had been infected there had been no need to invoke this protocol.

Regular audits of the COVID-19 procedures and processes were carried out. These had found compliance of a high standard and this correlated with our observations during our inspection. There were also more general IPC audits which included hand hygiene. These too showed compliance to be to a high standard.

As an infection prevention measure the provider asked patients to move directly to treatment areas from the entrance. Patients, who usually arrived by private car were asked to contact the clinic and wait until asked to come into the building. They were asked not to socialise with other patients or staff and the facilities provider had made arrangements for all activity that could be done remotely to take place that way. For example, exercise classes and well-being therapies took place by video call.

Facilities that were normally available such as self-service drinks machines, magazines and patient information leaflets had been removed or taken out of service. When facilities were essential, they were provided in a safer way, usually by staff so the need for patients touch items that had been touched by another person was minimised.

We discussed with the registered manager the processes that the service had in place to test asymptomatic staff for COVID-19. The provider had introduced twice weekly home testing for staff using lateral flow technology. This was done on Wednesdays and Sundays so as to allow any changes to staffing to be accommodated should a result be positive. If a member of staff tested positive, they would be required to access COVID-19 Polymerase Chain Reaction (PCR) test through the NHS.

Staff practised Aseptic Non Touch Technique (ANTT) when appropriate and there was a policy to manage this. We did not have the opportunity to observe staff carrying out this technique, but they were able to confidently describe what they did.

Good

Medical care (Including older people's care)

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 building was purpose built as an oncology facility and had many features to keep people safe and to aid effective treatment. The clinic had received the Macmillan Quality Environment Mark which provided assurance that the environment is suitable for cancer treatment.

The clinic was split into two areas. One area held the radiotherapy and imaging equipment and was built to accommodate the need for radiation shielding and to regulate access to radiation controlled areas. There were suitable warning signs in line with relevant legislation. The patient areas were comfortable and safe. There was enough, suitable lifting equipment to ensure patients could be moved and handled safely.

Chemotherapy was delivered in six individual “pods” which were of a standard design and the same equipment was used across them all. These pods were clean, comfortable and had plenty of space for a patient to be accompanied by a relative or friend while staff had enough space to carry out their work safely. We noted that oxygen cylinders were stored in a suitable dock which was a purpose-built mounting located on the wall of the pod. There was also a treatment room for patients that needed or wished to lie down for their therapy.

Medical devices were standardised across the clinic and staff had been provided with training on the specific model of equipment that was used. When we looked at training records, we saw that this was recorded accurately and when appropriate that staff had their competence to use devices assessed before they were deemed as trained. Although the training records appeared to record competences on generic equipment types such as “infusion pump” because the organisation used only one model of each category all training was, in effect, model specific. This could be seen clearly in that all relevant staff had recently received certificates following training on the new infusion devices.

Staff reviewed training in the safe use of medical gases, including oxygen, as part of their yearly mandatory training. Local compliance with this module was 96%.

The organisation had an asset register of the medical devices. We were told that maintenance records were held centrally and were not available locally. However, we looked at a significant number of medical devices and in all cases, they were labelled to indicate that they had been serviced and there was a date stating when the next service was due. No device had gone beyond its next service date.

We were told that most medical devices were maintained through contracts by the manufacturer. Where devices such as patient hoists and weighing scales needed to be maintained by a competent agency it was clear from the labelling that this had been done.

Significant pieces of equipment such as the linear accelerator were maintained through a companywide arrangement of qualified and competent technicians. Provider employed technical staff were called on site in the event of a fault and staff told us that the response time of one hour were satisfactory.

If the radiotherapy treatment equipment was unserviceable the provider had established arrangements to ensure that patients could be treated at another Genesis centre.

Good

Medical care (Including older people's care)

Staff received fire safety training each year as part of their mandatory training. The local compliance rate for this module was 100%. Fire alarms and associated systems were regularly tested.

During our walkaround of the unit we noted that the corridors were uncluttered, that fire exits were not obstructed and that they were clearly signposted. Firefighting equipment was suitably placed and had been maintained as required. Fire doors, which prevent fire spreading within a building, had self-closing mechanisms or were linked to the fire alarm system and would automatically close in an emergency.

However, we noted that the fire door to the patient kitchen was wedged open. Many members of staff walked past without identifying this risk which was significant because kitchens are one of the most frequent places that a fire starts. We pointed this out to the registered manager who closed it and said they would remind staff of the need to keep fire doors shut.

The local risk register showed several assessed risks that involved fire safety. However, these were all assessed as low and effective mitigation was in place while the issues were resolved.

Resuscitation equipment and medicines were stored in two purpose-built resuscitation trolleys and these were positioned so that they were closest to locations where they would most likely be needed. The contents of each trolley were identical and were suitable for the emergencies that might occur in the clinic.

There was a procedure where the full contents of each trolley were checked each week and the drawers were secured using an easily broken plastic security tie. Each day there was a check that this tie was unbroken and the items that were stored loose on top of the trolley, including medical devices such as the suction machine, were also checked. Records were kept of this and we could see that the process was adhered to.

There was also eyewash equipment available next to the resuscitation trollies as well as orange glucose boxes that contained the monitoring equipment and medicines to treat a patient suffering from a hypo-glycaemic attack.

There was a Waste Management Policy which covered clinical, cytotoxic and domestic waste.

Pharmacy cytotoxic waste was destroyed according to a suitable process. It was put into colour coded bins then heat sealed between each deposit of waste. The waste was taken away through a contract with a waste company for incineration at a suitably authorised facility.

A cytotoxic spill kit was located in the treatment room adjacent to the chemotherapy treatment pods and there was a policy in place. Staff were familiar with the process and explained what they would do including donning of PPE, cordoning off the area and using absorbent pads to and bleach solution to clean.

There was a store of the kits available for patients who took chemotherapy home. We confirmed that patients were training on how to use chemo spill kits at home.

Non cytotoxic clinical waste was usually stored correctly and disposed of through a contract with a suitable company. However, when we entered the cleaner's store at lunchtime, we noted that a yellow clinical waste bag had been temporarily stored there alongside black domestic waste bags. We drew this to the attention of staff and it was resolved.

The clinic held a radioactive sealed source. There was an effective policy in place to ensure that it was managed safely. This policy gave instruction as to how to deal with any incident including liaison with the local fire and rescue service.

All patient toilets had pull cords that activated an emergency alarm.

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 patients underwent a thorough assessment prior to treatment and there was a defined set of information to be provided by the referrer without which treatment would not go ahead. This was audited and we noted that the local compliance score was 99%.

When patient attended for chemotherapy treatment, blood tests were done in advance of the first treatment session to ensure they were within normal range. This was able to be repeated using an analyser within the department and if concerning they were escalated to a consultant. Options might be to defer treatment for a week or to treat on consultant confirmation or prescribed medication to increase white blood cell count. This represented a good approach to managing patients with low white blood cells who would be at risk from infection and was managed under the provider's Neutropenic Sepsis Policy.

Each morning the staff took part in a "Daily Huddle" with the manager where they received a briefing for the day. This included identification of the resuscitation team and the designated leader, first aiders on duty and an incident team. Staff were briefed on patients with any particular needs, any ongoing risks, rapid alerts as well as learning from incidents.

Patients were encouraged to telephone the department if they felt unwell. They were given specific information about sepsis and how to act if they were concerned. If necessary, staff would advise the patient to come in and perform a set of clinical observations. If this raised concerns, there was liaison with the patient's consultant, and they would be seen by the Resident Medical Officer (RMO). There was an established pathway arrangement with the local NHS hospital to ensure that in working hours patients would be admitted through contact with an NHS oncology nurse. Out of hours accident and emergency would be used but the oncology service would be informed.

Out of hours there was a nurse led 24-hour assistance line which used the United Kingdom Oncology Nurses (UKON) triage tool and they would advise the patient on what to do including attendance at A&E.

There was a suitable sepsis policy and procedure in place. The clinic had sepsis bundles that could be prescribed by the patient's consultant or the RMO. A first dose of antibiotics would be administered on the say so of the consultant or RMO. There would then be liaison with the local hospital to admit the patient by ambulance.

In the preparation area outside of the CT scanner there was a suction machine and a poster clearly showing the procedure to be undertaken in the event a patient suffered an anaphylactic reaction.

There was no psychology service within the clinic, but staff knew how to recognise when patients needed this support and they would be signposted into other services.

The provider used an external company for resuscitation training, and they had just changed the company that they used. We were told that the previous provider had used scenario training where staff "play out" their actions in a realistic setting and that this would continue with the new provider.

Good

Medical care (Including older people's care)

All staff received Basic Life Support (BLS) training. All clinical staff had received Intermediate Life Support (ILS) and the RMO was trained to provide Advanced Life Support (ALS). Under the new training arrangements lead nurses would also be trained in ALS.

When we asked staff about any emergency situations that had occurred, they were able to give two examples.

In one case a patient had arrived for treatment and was recognised by the staff as being unwell. The provider followed their protocol and arranged for an urgent transfer to the local NHS hospital by the ambulance service. While waiting for the transfer the staff had ensured that the patient's condition was monitored using the required early warning scoring systems and consideration was given as to the risk of sepsis given their presentation.

In another example a patient had developed a rare, but well recognised, life-threatening complication of their chemotherapy treatment. The provider had provided mandatory training for staff in dealing with this situation, had an established protocol and the equipment needed was immediately available. We spoke to two members of staff who were involved in the successful treatment of the patient and their accounts were consistent with the patient's notes that we reviewed. The patient suffered no harm and staff were rightly proud that the arrangements made by the provider together with their own actions had resulted in the best possible outcome from this emergency which was full recovery of the patient.

The organisation had a policy for managing the unusual, but important, circumstance when a radiotherapy patient was pregnant. When we asked staff about what they would do they were unsure but knew that there was a policy to which they could refer.

We looked at the policy with staff and saw that it stated that a urine test should be done and "if greater accuracy required to undertake a blood test" and to escalate to consultant. There was no clear definition on what "greater accuracy required" meant and when it might be needed. Staff could not offer an explanation as to how they would act.

Staffing

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

All nursing staff were employed directly by the provider other than one who worked as "bank" staff. There was only one open vacancy for a nurse, but they did have a shortfall in administration staffing. This was on the local risk register and this noted that lack of administrative support was having some effect but not on patients.

We were told that staffing was not usually a problem. The clinic had low rates of sickness and staff turnover was very low. We asked how any staff shortfall was managed and we were told it was done by cancelling leave, altering patient attendance and requesting staff from other clinics in the organisation. There was the provision to use agency staff, but this was a last resort.

Because of the specialist nature of the service all staff had the same competencies so, other than to ensure someone able to lead the shift was always on duty, there was no need to have a staffing system that took account of different skills or specialities.

We examined nursing staff rotas for the previous two months and noted that there was no staffing shortfall on any shift.

Good

Medical care (Including older people's care)

New staff were always had previous experience and evidence of training was required on appointment. All new staff followed a 90-day induction programme during a three-month probation period. The learning and competency requirements were specified in a policy and we were able to see this documented, including copies of training certificates for recent starters.

There was a specialist breast care nurse available in the clinic.

There was a Resident Medical Officer (RMO) who was suitably qualified and experienced to provide medical cover present on the unit at specified times. The provider's protocols ensured that procedures that carried a higher degree of risk such as the use of contrast agent or the administration of Systemic Anti-Cancer Therapy (SACT) medicines were only given when the RMO was present. During our observations of the service we noted that this was always the case.

The RMO was provided through an agency although it was normally the same doctor or in their absence others who were familiar with the service. We noted that there was a good working relationship between the RMO and the nursing staff and they spoke highly of each other.

Consultant medical staff worked under practising privileges. The authority to practice was granted by the organisation's Medical Advisory Committee (MAC) when they were satisfied that their medical practice would be safe. When we reviewed notes of this committee, we noted not only that doctors had been granted practising privileges but, in some cases, this had been refused or the privileges restricted. This demonstrates good medical governance and oversight.

Records

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

The clinic used a proprietary electronic record system that was specifically designed for cancer treatment. Access to this was by individual usernames and passwords and we saw that staff ensured that they "logged off" when they left the computer. Some records were paper, and these too were stored securely.

There were plenty of computer facilities to access the system within the clinic and staff had access from home when they needed to include medical staff with practising privileges.

We reviewed a sample of four patient records, two within chemotherapy and two in radiotherapy and found that the records had been completed well.

We were told that the provider had introduced an audit of chemotherapy documentation and this had resulted in an action plan. Asked what this process had uncovered staff told us that production of a quality letter to the patient's GP was the biggest problem and this was being addressed.

Medicines

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

The service had a medicines management policy. Staff were fully familiar with it and our observations confirmed that they acted within it. There was oversight of this and associated polices including a Safe Prescribing Handling and Administration of SACT Policy (Chemo Policy) by a Medicines Management Committee.

The pharmacy room had keypad access and all cupboard and fridges were secured with locks. Fridge temperatures were monitored and recorded, and we did not note any issues.

The pharmacy staff explained that controlled drugs were ordered and processed centrally. Each centre ordered a set stock and then a pharmacy staff member had to receive the stock within their system and sign. There was however a monthly stock count check for all drugs completed. During our inspection this was examined, and no issues were identified. The clinic did not hold any of the type of controlled drugs which required a stock recording system.

The provider used an electronic prescribing system. Pharmacy staff screened prescriptions and arranged for them to be provided from an external supplier. The hospital used a selection of Systemic Anti-Cancer Treatment (SACT) medicines that were used for specific tumours. The clinic had recently introduced new pumps for the intravenous injection of chemotherapy drugs. This was done as a pilot for the overall organisation and had proved successful. These pumps used a built-in electronic drug library and these systems are known to reduce drug errors.

Consultants could prescribe other treatments that were not in the protocol as well as drugs that were “off-licence”. This was subject to oversight by the Medical Advisory Committee (MAC).

Consulting rooms, treatment areas and offices had “Have you paused and checked” posters from the Society and College of Radiographers to remind staff of the need to do this.

Contrast agent, which is a medicine used to enhance x-ray scans was prescribed by a doctor and was delivered against a defined process. We observed two CT scans during our inspection, and we saw that the requirement to pause and check was carried out to confirm patient details and the contrast against the referral. This was done by both the radiographer and the RMO immediately prior to the scan and the patient also signed to confirm their understanding and give consent.

We examined the document that was used to check the use of contrast and this was in line with the Royal College of Radiologists guidelines.

The organisation had a suitable and comprehensive extravasation policy. We asked if such an event had happened recently and were told of one that happened a few months previously. The staff member described their actions which were in line with the policy. This included an explanation to the patient who was given an information leaflet and called the next day to check on them.

Daily checks for emergency medicines in the CT scanner room were recorded electronically and we saw that this was completed accurately and consistently. The emergency drugs kit was locked in a cupboard in the CT scanner room, the kits being dispensed by the pharmacy and secured with a seal and an expiry date of the earliest expiring drug displayed. We saw that on the day of inspection all the drugs were in date. Within the cupboard the ambient temperature was taken and recorded in the daily check.

Contrast agent was warmed in a warming device in the control area. We saw evidence that the temperature of this was monitored and recorded daily. The warmer held stocks of contrast and each vial was single use with the date of stocking, together with the one-month expiry date written on it.

Incidents

Good

Medical care (Including older people's care)

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The provider had a detailed Incident and Risk Management Policy (UK). This described how to deal with a variety of incidents, both clinical and non-clinical as well as how to distribute and action safety alerts from various bodies. It also described the providers own internal “rapid alert” system.

We saw that there was a computerised system for recording incidents. When we asked staff about the incident reporting system, they were all able to describe incidents that had been reported.

We asked staff about any recent serious incidents and those that they described were noted on the system, had been reviewed and staff had been provided with feedback. We also saw that because one of these incidents had involved an adverse reaction to a medicine it had been reported to the Medical and Healthcare products Regulatory Agency (MHRA) using the “yellow card” system.

When we looked at entries on the system, we saw that it was often used by staff to report concerns. This is indicative of a good safety culture in that staff know that their reports are worthwhile and that their reports are welcomed rather than seen as a problem by managers.

We asked how incidents were managed so that all the provider’s clinics benefitted from learning as a result of incidents. We understood that all clinical incidents were discussed in the weekly Risk and Safety Committee which was a cross clinic online meeting. When we asked for an example, we were told of an error which occurred in another clinic when the wrong giving set had been used to administer a medicine. As a result the provider had issued a “Rapid Alert” to all the clinics in the company which was disseminated to relevant staff and a laminated card had been produced to remind staff that the correct, filtered giving set was always to be used. Further to this new drug pumps had been introduced which used a built-in electronic drug library system that alerted staff to the need to use a filtered giving set for certain medicines.

We asked how alerts made by external agencies such as manufacturers, the National Reporting and Learning System (NRLS) or the MHRA were managed. The registered manager explained that this was administered through the provider’s central office and they were sent a regular list and required to make a response as to whether each one was relevant to the clinic or not.

Should any action be needed it was actioned and the central office was informed when it was completed. We asked for the most recent example of this having been done and were told of a faulty batch of a medical device that had to be identified, taken out of use and a replacement batch ordered. We asked for and were shown evidence that this had been done.

When we spoke to a radiographer who was administering contrast agent, they were familiar with a safety alert that warned against drawing up agent for multiple patients to keep in the warmer and confirmed that they did not do this.

Staff were familiar with duty of candour requirements and there was a two-yearly mandatory training module. The local compliance rate for this training was 100%

Are Medical care (Including older people's care) effective?

Good

Medical care (Including older people's care)

Good

We rated it as good because:

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.

Patients were treated according to the provider's policies and procedures which were based on national guidance and protocols from a variety of organisations that promoted best practice. These documents were available to staff online and there was signed documentation to record that staff had read and understood them.

There was oversight of these policies and procedures through provider level committees for radiotherapy and chemotherapy.

All radiotherapy protocols for treatment were stored in the electronic patient record system.

There was a comprehensive audit policy which, amongst other things, audited compliance against treatment pathways and the associated policies and procedures. Compliance was very high and provided assurance that treatment was in line with guidance and best practice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs during treatment. The service made adjustments for personal preferences.

The service employed an "in house" dietitian who was available to all patients. We were told all patients were automatically referred to them and we saw from patient records that this was the case. Patients were assessed using a recognised tool and received suitable advice and support for their individual circumstances.

We saw posters referring to the need to eat well during treatment.

Patients were able to order lunches for themselves and anyone accompanying them in advance of their treatment and snacks and drinks were available at any time.

Patients to whom we spoke were very satisfied with the quality of the food they were offered.

Staff involved in the preparation and distribution of food and drink received a yearly training in food hygiene as part of their mandatory training. Local compliance with this module was 100%. Staff were aware of the risk associated with food allergies and had recognised a potential risk with their food supplier which was being well managed.

Pain relief

Good

Medical care (Including older people's care)

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They also assessed and provided relief for other distressing consequences of treatment and disease.

Pain relief was available to patients through the RMO and nurses who prescribed against protocols. Patients were always asked when they attended about pain and discomfort.

The clinic also worked with a local hospice to support pain relief for patient's individual needs and the service had access to consultant medical staff from the pain service at the local NHS hospital. There was also access to advice about nausea from this service.

We saw examples of referrals to these services as well as the local NHS Community Palliative Care Team.

A patient told us that they were always offered pain relief and anti sickness medication and as well as drinks and mouthwash to deal with their dry mouth.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements

There was a comprehensive audit policy which, amongst other things, audited compliance against treatment pathways and the associated policies and procedures. Compliance was very high and provided assurance that treatment was in line with guidance and best practice. Where there was a shortfall we saw plans were put in place to address identified issues.

Following an unsatisfactory Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} in 2020 an improved audit system had been introduced across the radiotherapy treatment provision of the organisation. There was a schedule in place for a 12-month period and each audit was done twice a year. Audits included patient identification, pathway audit, entitlement of staff, dose badge wearing and pregnancy. All audits were completed for five patients at the clinic centre. This we noted was a relatively small sample but appropriate and representative of the low number of patients seen.

Audit also took place across the chemotherapy provision and included documentation, the offering of scalp cooling and vascular access.

We were provided with audit compliance figures for the organisation and we saw that compliance figures for the Milton Keynes Centre were very high, both in terms of the individual scores and adherence to the schedule.

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.

There was an overall Induction Learning and Competency Policy which described how these matters were to be managed across the organisation.

We saw that the computerised human resources system used by the provider included training records. When we asked to see examples of training records they were readily available and managers were able to demonstrate various reports that enabled them to have effective oversight of staff training.

Good

Medical care (Including older people's care)

The organisation kept a record that staff requiring registration with a professional body were registered. We examined these records noted that they included the expiry date and highlighted those staff who were coming up for renewal.

Each clinical staff role in the organisation had a competency framework. We saw these in place for staff supporting the chemotherapy service. When we observed a radiographer carrying out a CT scan we checked their competencies for this activity and noted that they were signed off as competent.

These competencies were changed and developed in order to keep up with developing standards and good practice. For example, the competencies for nursing staff working in chemotherapy were being developed to include the United Kingdom Oncology Nursing Society Systemic Anti-Cancer Therapy guidelines.

New starters were required to complete their competencies within three months of starting. All staff made a yearly annual competency declaration which was signed off by their supervisor. Senior staff had their competencies signed off by a peer from another clinic or the organisation's chief nurse.

We asked to examine records and saw completed assessments for relevant competencies including catherization and managing extravasation in line with the organisation's policy for this emergency.

Some radiotherapy staff told us that they did not have the opportunity to expand their clinical practice to include, for example, cannulation or the administration of contrast.

Staff received regular supervision and had one-to-one meetings with their managers.

Multidisciplinary working

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

Multi-Disciplinary Team (MDT) working is important to good cancer care. MDT meetings are a forum in which a group of health professionals come together to discuss and plan the best treatment option for each patient. Polices such as the Safe Prescribing Handling and Administration of SACT Policy (Chemo Policy) and radiotherapy pathways required that an MDT take place prior to treatment. This was assured through quality audits of referrals.

Some MDTs ran internally; for others, consultants were required to discuss the patient within the MDT meetings of the NHS trust in which they worked.

We saw that enhanced oversight and audit of MDT meetings had introduced through the provider's "Cornerstone" project which is a plan to improve organisational governance.

Outside of this formal arrangement we noted that the different staff groups within the clinic worked very well together and demonstrated resect for each one another.

Seven-day services

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

Good

Medical care (Including older people's care)

The clinic was open during weekdays, Monday to Friday.

There were robust arrangements for patients to obtain advice via a 24-hour helpline from a specialist nurse employed by GenesisCare and they would arrange emergency care through the NHS as necessary.

Health promotion

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients benefitted from access to an exercise clinic. Staff in the exercise clinic would prescribe an exercise regime to support healthier lifestyle and aid recovery.

All patients were referred to the clinic's physiotherapist led exercise service and the patients had to opt out if they did not wish to participate in this element of support. It was made clear to patients that it did not replace specialist treatment such as a lymphoedema clinic that was offered elsewhere as part of their treatment.

This provision was evidence based around research that showed that "exercise medicine" improved not only mental wellbeing but also tolerance of chemotherapy cycles, minimised dose reduction and helped with fatigue from radiotherapy.

A baseline questionnaire was completed for all patients and this enabled the collation of patient recorded outcome measures.

The clinic had a large and well-equipped exercise room with free weights, a treadmill and exercise benches. A personal trainer worked alongside a physiotherapist to guide and support patients with exercise.

At the time of the inspection all therapist led work took place in a virtual on-line environment. We were told that initially this was one-to-one but that most patients wanted to exercise in a class and so while one-to-one would still be available, shared sessions were more common.

Each patient had access to an app in which the physiotherapist defined an individual plan including two self-directed sessions and one on-line session per week.

We asked whether there was a smoking cessation programme within the clinic and we were told that there was not.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The provider had a consent policy that referenced UK law, human rights legislation and guidance from the Department of Health and the General Medical Council. The policy was comprehensive, detailed and described how consent must be obtained and recorded.

Good

Medical care (Including older people's care)

The policy stated that "GenesisCare UK will only treat adult, mentally competent patients, who have been given sufficient information by the referring Consultant, to enable that patient to give valid consent for the proposed treatment or procedure." This policy, that precludes treatment of patients who are not "mentally competent" might be discriminatory.

This policy also appeared at odds with the providers Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) policies which allowed for the treatment of patients who lacked capacity through advanced directives, best interest decisions and the involvement of advocates.

We asked for an example of when it might have been used and several staff recalled a patient with some dementia who was confused when signing for consent. Staff conducted a mental capacity assessment and judged that they did not have capacity for this decision. A family member had powers of attorney and with legal advice the patient was able to be treated, legal consent having been obtained.

Consulting rooms and treatment areas all had posters on the wall mentioning the availability of chaperones and how to request one.

Staff received yearly updates for consent, depravation of liberty safeguards and mental capacity as part of their yearly mandatory training. Local training compliance for these modules was 100%.

Staff were knowledgeable and confident about these matters despite it being infrequently needed in the service.

Are Medical care (Including older people's care) caring?

Good

We rated it as good because:

Compassionate care

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

Although the requirements of social distancing and enhanced infection control arrangements by the provider meant we were only able to speak to a limited number of patients and relatives all the feedback we received was highly complimentary.

Patients told us that they felt "safe", "cared for and confident"

During our visit we observed radiographers working with two patients and nurses working with patients receiving chemotherapy. They were courteous, kind and listened to the patient offering them blankets to keep warm good interactions.

During our visit we observed radiographers working with two patients. Dignity and privacy was maintained as staff used a curtain for privacy within the scanning room to stop other staff in the control room from seeing a patient when this was not necessary.

Good

Medical care (Including older people's care)

Staff shared feedback received recently from patients that they felt that coming for chemotherapy felt safe and they were looked after. The staff believed that they were able to give time and a personal service to patients. We also saw letters of thanks including a poem written by a patient and these were very complimentary of the staff and their experience at the clinic.

This was corroborated when a patient told us that they felt relaxed and that they were in a comfortable environment.

We asked for copies of recent patient surveys. They demonstrated that patients were highly satisfied with care, privacy and dignity they experienced.

Emotional support

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

Both staff in the chemotherapy and radiotherapy suites used private “quiet rooms” for those sensitive conversations when patients might become upset.

The provider encouraged relatives or carers of patients to access the wellbeing services on offer. As well as providing them with support for their health and wellbeing it had a positive effect on the patients too.

Wellbeing support was offered through in-house provision as well as through a partnership with a national cancer support organisation.

Understanding and involvement of patients and those close to them

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

A patient told us that staff communicated very well with them.

We asked for copies of recent patient surveys. They demonstrated that patients were highly satisfied with how their treatment and any side effects were explained. They also scored similarly highly for the patients view of how they were involved in their healthcare.

The clinic was accredited through the Macmillan Environment Mark standard which assured the quality of the patient experience.

Are Medical care (Including older people's care) responsive?

Good

We rated it as good because:

Service planning and delivery met the needs of the local people

Good

Medical care (Including older people's care)

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

Facilities and premises were appropriate for the services being delivered. The centre was light and spacious. There were plenty of consultation rooms, treatment rooms and private rooms for patients to use.

All rooms in the service were clearly labelled and had signs to indicate when they were occupied.

Toilets were located throughout the centre and had call bells on red pull cords to call staff, if patients required assistance. The service was easy to get to and the carpark had plenty of free parking spaces. The service provided patients with taxi transfers from home to the centre, for the treatment so, patients and those close to them did not have to worry about how they would get to the centre.

The service had systems to help care for patients in need of additional support or specialist intervention. If a patient deteriorated whilst in the centre, the service had a clear patient pathway under an agreement with a local NHS hospital. The service could also refer to the local NHS trust for specialist care.

The service had systems to help care for patients in need of additional support or specialist intervention.

The service did not stop or delay treatments during COVID-19, having been able to reassure patients at beginning of the pandemic.

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.

We understood that in normal times patient information leaflets were available on relevant topics in the patient areas of the clinic. However, these had been removed as an infection control measure because of COVID-19.

Instead, the clinic made information available to patients by giving leaflets directly to patients and signposting to online resources. Information leaflets were available in a variety of languages through Macmillan Cancer Support and were printed out as needed.

The clinic had cold cap machines available for patients to use, if they wished, which reduced hair loss from some chemotherapy treatments.

The patient areas of the clinic were all on the ground floor and there was either level access or very shallow ramps to all areas of the building. There were wheelchairs available should they be needed including larger ones for patients who needed them.

We asked how the service supported patients for whom English was not the first language. We were told that Arabic was the most common other language, but that most of those patients spoke good English. The clinic had access to a language line facility through an arrangement with an external provider. Staff told us of instances when this had been useful and effective.

Good

Medical care (Including older people's care)

For other patients with communication needs documents and information in brail could be requested from Macmillan Cancer Support. There was a portable hearing loop in reception that could be taken with the patient to other areas in the clinic.

Equality and diversity was a mandatory training module and the local compliance rate was 100%.

Patients told us that the clinic allowed them to bring friends and relatives to appointments which was important to them as they needed the support.

A patient spoke positively of the food and drink, particularly the hot chocolate and they said that they were able to choose from lots of options.

Staff received training in meeting patient's needs and they were given resources to do this through a "Patient Experience Playbook". There were Customer Experience Champions who provided leadership for this initiative.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

All referrals were for privately funded patients. The unit was open from 8am until 8pm each weekday although therapies only took place from 8:30am until 5pm. The clinic had excess capacity over and above the referrals that they received and thus wait times were within national guidance.

We were told by a patient that the service was accommodating and that they were able to choose convenient appointments. Patients did not usually wait for treatment after their booked time.

The most recent patient survey scored 100% satisfaction for access to the service.

If treatment was not available because of, for example, a machine breakdown then the service arranged for treatment to be give as soon as possible at one of the providers' other locations.

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.

There was a provider wide complaints and concerns policy. This defined how different complaints should be handled, at what level in the organisation and by whom. As a member of the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) the complaints procedure was aligned with their requirements.

Good

Medical care (Including older people's care)

The complaints policy indicated how complaints could be made, escalated to or drawn to the attention of other bodies, including the CQC, and it correctly described the role and remit of those bodies. The complaints policy differentiated between the remedies available to patients who were funded by the NHS and those who were not. Only NHS funded patients have recourse to complain to a commissioning body and the Parliamentary and Health Service Ombudsman (PHSO).

The complaints policy referenced the statutory duty of candour contained in the regulations and defined clear processes to ensure the organisation complied.

We asked the registered manager to describe the last three complaints that the clinic had received. They were able to do this confidently and explained the rationale behind their responses to the complaints.

We asked to see copies of the complaints and the responses correlated well with what the manager had described. All the complaints had been responded to well.

Complaints were regularly discussed at a provider level including in the Risk and Safety Committee when this was appropriate.

We were given examples of how changes had been made as a result of patient feedback. The clinic had sourced better coffee and snacks on the back of feedback. We were also told a patient mentioned that a picture in the chemotherapy suite had "spikiness" and reminded them of a tumour cell. This gave the patient a negative feeling. This was something the staff had never considered previously so they replaced this picture with flowers.

Are Medical care (Including older people's care) well-led?

Good

We rated it as good because:

Leadership

Managers at all levels in the organisation had the right skills and abilities to run a service providing high-quality sustainable care.

The clinic had a well-established leadership team who worked well together. Clinical leadership had been enhanced and the positive manner in which senior staff worked together was evident from interactions we saw.

Senior provider wide leaders were frequent visitors to the site and outside of this were accessible to local staff.

The registered manager and senior clinical staff had a very strong joint understanding of the day to day issues in the clinic and the unit was managed consistently.

Staff spoke positively of senior leaders and those leaders expressed confidence in the people who they managed.

Vision and strategy

Good

Medical care (Including older people's care)

The provider had a vision for what it wanted to achieve and workable plans to turn it into action.

GenesisCare UK had an overall corporate strategy. Each location, including Milton Keynes had a strategy that was aligned with these overall goals and plans to achieve it. Staff were aware of this strategy and knew about the different initiatives that were relevant to their work.

Following an unsatisfactory IR(ME)R inspection in early 2020 the provider had overhauled its governance arrangements through a project "Cornerstone". Staff were familiar with the aims, objectives and importance of this programme.

Staff were aware of the corporate values of "empathy for all, partnership for all, innovation every day and bravery to have a go and integrity always".

Culture

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

All staff we spoke with talked positively about the provider and people with whom they worked. They told us that they felt listened to and part of the team.

There was a friendly but professional atmosphere in the clinic and staff appeared to work well together.

We asked for a copy of the staff survey of November 2020 which was comprehensive and did not raise any serious concerns. A discussion took place as to how, because of COVID-19 the senior leadership team had been less able to visit centres. The provider had introduced a "buddy" system to ensure all staff still felt supported.

Staff told us that they worked in an open culture where they were not afraid to raise issues. This was corroborated, to some extent, by the use of adverse incident reporting by staff which indicated that they were unafraid to speak up and had confidence that the issues would be dealt with.

However, we noted from the most recent staff survey that the lowest score was for "trust in the doctor group" which scored 68% as favourable and 32% as neutral. We took any concerns to be with the consultant medical staff as we observed a very good working relationship between staff and the RMO.

Governance

There was a systematic approach to continually improve the quality of services and the safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There was a clear governance structure in place, this had recently been revised through the provider's Cornerstone project. We saw an overall schematic of how this governance system operated with its attendant committee structure.

Good

Medical care (Including older people's care)

Aside from the board at national level there were committees that covered clinical leadership, research, quality and safety, a MAC and a safety and risk forum. Technical sub-committees fed into a safety and risk committee included those with the oversight of radiotherapy, chemotherapy, diagnostics, and radiation safety. Similarly, clinical sub-committees covering nursing and professionals allied to medicine, health and safety, information governance and mortality/morbidity were in place.

There was strong guidance on the scope and responsibilities of each committee and how they interacted with each other. There was representation at national level through each clinic's registered manager and individual staff groups had representation.

These arrangements had been recently introduced but we saw how they were already becoming embedded through the notes of local meetings and through talking to both clinical staff and their managers.

As part of what was branded the organisation's "rhythm of performance" there was a comprehensive system of audit with assessments of performance taking place to different schedules appropriate to the audit in question. We saw that where local audits revealed failures of compliance or a deficit in performance, suitable action plans were put in place.

Management of risk, issues and performance

There were effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected

We asked the registered manager about how they knew about any risks that were present in the service and we were told that there was a risk register in place. We asked them to describe the three most significant risks that were present.

We noted that their answers correlated exactly with information that other staff had given us during our visit and the copy of the local risk register that we obtained. The manager spoke knowledgably about each risk and plans to eliminate or mitigate them.

There were six risks on the local risk register and five of them were brought up by staff during our conversations with them. This demonstrated a high level of local knowledge about risk.

There was a Radiation Protection Advisor (RPA) available within the organisation and locally safety was overseen by radiation protection supervisors for each modality. Local rules were written to a standard format but were adapted, as required, to local circumstances. Relevant staff worked to those rules and there was governance in place to ensure that they signed to say they were aware of them. Treatment protocols were developed under the approval of a Medical Physics Expert (MPE). The RPA and MPE where appropriately involved in relevant governance committees such as the radiation safety committee and clinical fora.

Information management

The provider collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards.

Most of the information systems that the provider operated were computerised and we noted that whenever we asked a question during our inspection there was an easily obtained report or spreadsheet that answered it. This demonstrated that managers and staff had the information available to them to manage the service.

Good

Medical care (Including older people's care)

We saw that there was a comprehensive Information Governance Policy and Framework in place which was aligned with relevant legislation. This covered a wide variety of topics including data breaches, data sharing, CCTV, data subject access to records as well as basic information governance practices and responsibilities.

Information governance formed part of the yearly mandatory training for all staff and the local compliance rate for this module was 96%.

During our inspection we noted that staff were diligent in the matter of ensuring that computer systems were secured when they left the desk.

Engagement

We saw evidence, through surveys and feedback questionnaires that the clinic engaged with patients and that changes were made when necessary. There was also the involvement of patients following complaints or incidents and again changes were made as necessary.

Similarly, the organisation carried out staff surveys however we noted that although most of the individual scores were satisfactory the completion rate was quite low at 51%.

Another means for the provider to obtain feedback from patients was through the Macmillan Quality Mark.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research, and innovation.

One of the provider's values was "Innovation every day" and we noted that improvement was discussed in local management forums.

The provider had a governance structure to oversee research and development and any activity only took place with approval. There was also strong oversight of any research activity through the MAC.

The clinic had been involved in the successful trial of new infusion devices which made use of a drugs library and which were integrated into the SACT treatment protocols.