Parkway

Quality Report

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

Ratings

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

Overall summary

Parkway is operated by Beacon Medical Services and has been based from its current location since 2015. The service provides a minor surgery, endoscopy, diagnostic imaging service (ultrasound) and an out-patient service for ear, nose and throat appointments.

We inspected this service using our comprehensive inspection methodology. We carried out a short announced inspection on 10 December 2019 and 12 December 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.

Summary of findings

The main service provided by this service was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery service level.

Services we rate

We have not rated this service before. We rated it as **Good** overall.

We found the following areas of good practice:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- 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 had enough medical, 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.
- 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 service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.
- 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.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- People could access the service when they needed it and received the right care promptly.
- It was easy for people to give feedback and raise concerns about care received.
- Leaders had the skills and abilities to run the service.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action.
- 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.

Summary of findings

- Leaders had established some governance processes within the service.
- Leaders and teams used systems to manage performance effectively.
- The service collected reliable data and analysed it.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.
- All staff were committed to continually learning and improving services.

However, we also found the following issues that the service provider needs to improve:

- The service did not always adhere to its recruitment policy.
- There was one example of a hazard substance not securely locked away.
- Governance processes were not always consistently applied to all areas, including partner organisations.

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.

Ann Ford

Deputy Chief Inspector of Hospitals

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	We rated this service as good because it was safe, effective, caring, responsive to patients need and well-led.
Surgery	Good	We rated this service as good because it was safe, effective, caring, responsive to patients need and well-led.
Outpatients	Good	We rated this service as good because it was safe, effective, caring, responsive to patients need and well-led.
Diagnostic imaging	Good	We rated this service as good because it was safe, effective, caring, responsive to patients need and well-led.

Summary of findings

Contents

Good

Parkway

Services we looked at
Medical care (including older people's care); Surgery; Outpatients; Diagnostic imaging

Summary of this inspection

Background to Parkway

Beacon Medical Services Group relocated to Parkway House in 2015. The organisation began as a partnership between three GPs in 2006 and was based in Didsbury, South Manchester. Beacon Medical Services Group Ltd was founded in 2010 and the organisation relocated to purpose-fitted premises at Parkway House. The service is commissioned by a number of clinical commissioning groups in the North West of England and delivers services for patients across north, south and central Manchester. It also accepts referrals from outside these areas. The model of care used delivered care within a community setting and closer to home for the local population.

The service provides the following regulated activities:

- diagnostic and screening

- surgical procedures

- treatment of disease, disorder or injury.

There is a registered manager in place

We have not inspected this service before.

The service did not treat children and young people at this location at the time of the inspection. The hospital also offers audiology services, but we did not inspect these services as they are outside the scope of registration.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two other CQC inspectors. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about Parkway

The service is commissioned to deliver minor surgery which consists of surgical consultations and the excision of lesions and cysts under local anaesthetic. It also undertakes routine diagnostic upper and lower gastro-intestinal endoscopy procedures. The outpatient clinics are for ear, nose and throat patients and nasopharyngoscopy procedures are performed as out-patient procedures. The service also provides diagnostic ultrasound scans. Magnetic resonance imaging scans were available from a mobile unit that visited the location every two weeks on a Saturday. The scans were delivered by a different organisation and so are not part of this inspection.

The service is located over two floors with endoscopy services being delivered on the first floor which was accessible by stairs and a lift. There were three clinic rooms for which minor surgery, ultrasound and ear nose and throat services were delivered. There was an office space for administration staff on the ground floor. The service does not have overnight beds. They did not treat children and young people.

During the inspection, we visited the service. We spoke with 21 staff including registered nurses, health care assistants, reception staff, medical staff and senior managers. We spoke with nine patients and one relative. During our inspection, we reviewed six sets of patient records and 12 staff files.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Activity

In the reporting period 1 July 2018 to 31 June 2019, there were 1307 minor surgical procedures, (4% of activity)

Summary of this inspection

1799 scopes (5% of activity), 10,015 ear nose and throat appointments which were out-patient activity (28% of activity) and 21,612 ultrasound appointments (62% of activity). All patients were NHS funded patients.

The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety:

- No never events
- Clinical incidents five no harm, two low harm, zero moderate harm, zero severe harm, zero death
- No serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- 28 complaints (zero referred to the ombudsman)

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Scanning services for computed tomography and magnetic resonance imaging
- Laundry
- Maintenance of medical equipment
- Pathology and histology

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 had not rated this service before 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.

Are services effective?

Good

We had not rated this service before. We rated it as **Good** because:

- Staff provided good care and treatment and gave patients 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.

Are services caring?

Good

We had not rated this service before. We rated it as **Good** because:

- 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.

Are services responsive?

Good

We had not rated this service before. We rated it as **Choose a rating** because:

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Summary of this inspection

- People could access the service when they needed it and did not have to wait too long for treatment.

Are services well-led?

Good

We had not rated this service before. We rated it as **Good** because:

- 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:

- Governance processes were not always consistently applied to all areas, including partner organisations.
- Staff at all levels did not always have 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	Good	Good	Good	Good
Surgery	Good	Good	Good	☆ Outstanding	Requires improvement	Good
Outpatients	Good	N/A	N/A	Good	Good	Good
Diagnostic imaging	Good	N/A	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

The main service provided by this hospital was surgery. Where our findings on for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We had not rated this service before. We rated it as **good.**

Mandatory training

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

For our detailed findings please see the section in the surgery report.

Safeguarding

For our detailed findings please see the section in the surgery report.

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.

There was an endoscopy operational policy that was signed and in date.

In all areas of the endoscopy suite there was personal protective equipment and we saw that people used it. In the decontamination room there were visors for the staff who worked in that area.

Water checks were carried out in line with organisational policy and national guidance. The water checks we looked at showed that there were acceptable levels of bacteria in the water.

Used scopes were covered with a red plastic cover before being moved from the scope room into the decontamination room, this was through a separate exit. Once in the decontamination room the scopes were processed before being put into the decontamination machine. There were two sinks in the decontamination room and two automated endoscopic reprocessors (AER's). Scopes were removed from the AER's into the drying cabinet. There was a bar code scanner for traceability.

There was a traceability audit and 50 procedures had been selected, this was within the reporting period. The information collected for the audit included the scope details with patients use. The information was cross referenced against the patient electronic records to check if all validation labels and manual cleaning records had been scanned. Compliance was good in 42 of the 50 procedures with the scopes being re-processed in the three hours before use. There was an issue with the scanning of the label in six of the labels scanned, two labels were missing. Following the audit an action plan was developed, and the results were shared at the governance meeting.

All sharps boxes were signed and dated and not overfilled.

There was a diagram on the wall showing how the scopes moved through the department.

There was a process for managing patients who had or were at risk of Creutzfeldt–Jakob disease

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 service had an endoscopy suite which was located on the first floor of the location.

The service met the requirements for the Joint Advisory Group for Gastroenterology (JAG) for patient environment and equipment. They were working towards accreditation.

There were two automated endoscopic reprocessors which decontaminated the seven scopes. There was a service contract which was in place from July 2019 to July 2020 and included maintenance visits.

There were seven scopes, four for gastroscopies and three for colonoscopies and flexible sigmoidoscopies. We saw that there was an inventory of all equipment in the endoscopy suite including serial numbers and service dates. The scopes were dried in the drying cabinet which was in the recovery room.

In the recovery room there was a patient trolley and two chairs for recovery.

There was a recovery trolley in the scope room and in the recovery room. These were checked every day and after being used, we saw that these checks were recorded. The oxygen cylinders were full and there were suction machines and defibrillators which were fully charged. All consumables in the trolleys were in date and the adrenaline was in date.

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.

An adapted World Health Organisation surgical safety checklist was completed before the start of each procedure. The service conducted quarterly minor surgery documentation audits, which included the surgical safety checklist and consent. The results for quarter three showed that of 20 patient records checked, 16 were fully completed and of the remaining four the sign out section was not completed. There were recommendations to improve compliance.

There were referral criteria for the service. The service did not accept patients who had insulin dependent diabetes, any suspected cancer referrals or any patients who were under 18. They would see a patient with a polyp but only if their previous polyp was smaller than one centimetre

Although the service did not accept patients who were referred on the two week cancer pathway they did accept urgent patients. There were criteria for these patients and we were told that they could be patients who had possible cancer symptoms but were not on the two week pathway. These patients were prioritised for treatment.

Where there was evidence or suspicion of cancer the local multi-disciplinary team (MDT) was informed within 24 to 48 hours. Staff told us that they could usually inform the team in less than an hour. Pathways were in place and histology results were forwarded directly to the MDT.

Histology reporting was done at a local NHS trust which was a cancer centre, this was where the MDT's were held. This meant that results could be forwarded to the most appropriate MDT in a timely way.

Patients with diabetes were listed first and there was a blood glucose monitoring meter and glucose available in the scoping room and in the recovery room. The service did not accept patients with type one diabetes.

There was a policy for the safe sedation of patients in endoscopy which was in date and had a review date.

Patients were asked if they wished to have sedation as part of the information that was sent out to them before their procedure. Restrictions on activities such as driving and operating heavy machinery if patients chose to have sedation were highlighted in the information pack.

Patients were offered a throat spray to numb the area before the endoscope was inserted.

We observed that the dosage of benzodiazepines and opiates were kept to a minimum to achieve sedation and that pulse oximetry monitoring was used on these patients.

We saw that patients who had received sedation were monitored every five minutes in the recovery room until they were ready to go home.

We saw that there was a laminated pathway on the resuscitation trolley for advanced life support and for anaphylaxis. We saw that checks were completed and documented.

Patients with poor renal function were required to have recent blood results, particularly the estimated glomerular filtration rate (a test to measure the function of the kidneys), with their triage form before they were prescribed the bowel preparation.

The service had anti-coagulation guidelines for patients who were on anti-coagulants.

Nurse staffing

For our detailed findings please see the section in the surgery report.

There was a bank of experienced nurses who worked on the endoscopy unit. All had or were currently working in NHS trusts in endoscopy services and had up to date competencies. The quality and operations lead for the service had experience of managing endoscopy services in an NHS trust.

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 staff a full induction.

There were four consultants who performed the endoscopies, all worked in the NHS and were experienced.

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.

For our detailed findings please see the section in the surgery report.

We saw that a register was completed after each procedure with patient details including name, date of birth, NHS number, procedure and consultant's name. This also included recording of the biopsies obtained during the procedure with helicobacter pylori (a type of bacteria) results.

The procedures were recorded electronically, and the images were stored on the system, this information could be transferred to the GP record.

Medicines

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

For our detailed findings please see the section in the surgery report.

Controlled drugs were stored in a locked cupboard in the endoscopy room. We saw that the appropriate documentation had been completed but there were no sample signatures from the consultants. We raised this during the inspection and the issue was immediately addressed. This shows the authentic prescribers signature when signing controlled drugs out for use.

There were sedation reversing drugs available in the endoscopy room and any use of a reversal drug was recorded as a clinical incident. We saw that the use of midazolam or any reversal drug was recorded in the controlled drugs book.

Prescriptions for bowel preparation were sent out by the service and were tracked and logged.

Incidents

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.

For our detailed findings please see the section in the surgery report.

There was an end of day form which recorded any cancellations, patients who did not attend, incidents, complaints and rebooking's.

Good

Medical care (including older people's care)

Any use of sedation reversing/antagonist medicines would be recorded as an incident. There had been no incidents with these medicines.

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

Good

We had not rated this service before. We rated it 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. Staff protected the rights of patients subject to the Mental Health Act 1983.

The service used guidelines from the British Society of Gastroenterology and from the Joint Advisory Group for Gastroenterology (JAG). The service was working towards accreditation.

The service used guidelines from the National Institute for Health and Care Excellence (NICE) for the referral criteria to ensure that all patients were suitable to have their procedure in a primary care setting.

Any new NICE guidance was discussed by the consultants and disseminated to the team. Team members had to sign and date to say that had read and understood the guidance and this was then incorporated into the systems and processes as appropriate.

Nutrition and hydration

Advice was sent out to patients about fasting before certain procedures. There was also advice on having sips of water up to two hours before the procedure. There was information about why patients were not allowed to eat or drink and the consequences of this.

Patients could request a glass of water in the recovery area.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

The service had started using a mixture of nitrous oxide and oxygen to help patients with pain relief and to reduce anxiety. This meant that patients could drive if they had used the gas and resulted in 60% of endoscopy patients having their procedure without sedation.

The service completed a patient comfort and sedation survey on all patients. There were no reports of significant discomfort and 173 out of 408 patients were noted to only have one to two episodes of mild discomfort during the procedure.

Patient outcomes

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

There was a clinical commissioning group scorecard that had been introduced in July 2019. We saw that the scorecard evidence was positive.

There was an audit programme for the service which included an annual review of referral guidelines, decontamination audits, scope tracking, environment, the consent process and any onward referrals to secondary care.

No patient had ever had a perforation and there had been no reported episodes of bleeding following the procedures.

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 nursing staff had worked or were working in NHS trusts doing endoscopy procedures. This was in all parts of the service including pre-treatment, scoping and recovery. They had many years of experience and worked well together as a team. The service monitored their competencies through the appraisal process and all staff had received an appraisal. Staff told us that they observed each other's competencies during procedures.

One of the nurses who worked at the service was an upper gastro-intestinal specialist nurse.

The quality and operations lead for the service was an experienced endoscopy nurse and had managed

endoscopy services in an NHS trust. Staff told us that the service had improved since they had joined the organisation. Staff told us that they would not work for the service if they were not assured of the quality of the service.

One of the administration staff had trained as a scope practitioner to support the qualified staff. They had shadowed other staff and received training to develop their competencies.

Multidisciplinary working

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

We observed that all the endoscopy staff worked together and that patients moved seamlessly between the pre-operative part of the procedure through to recovery. There were protocols in place to support this. There was mutual respect between the health professionals. Staff told us that they felt that they could speak up if they were not happy with any part of the procedure.

Seven-day services

There was not a seven day service for endoscopy. There were nine endoscope sessions every month, these were held on different days of the week providing choice for patients.

Health promotion

Patients were given appropriate advice following their procedures.

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.

The service used postal consent, this satisfied the requirement from JAG to eliminate the practice of obtaining consent in the procedure room. Patients could telephone the service for advice and could ask questions prior to the procedure when they were in the sub waiting area. Consent was verified by the admitting nurse and the endoscopist and was part of the completion of the World Health Organisation checklist prior to the procedure.

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

Good

We had not rated this service before. We rated it as **good.**

Compassionate care

For our detailed findings please see the section in the surgery report.

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

We observed that staff were caring and treated patients with dignity and respect.

The service had a rolling programme of audit that included patient satisfaction, comfort, privacy and dignity and aftercare.

The patient satisfaction surveys were one document but patients could give feedback on individual services.

In the minutes of a meeting we saw that there had been some issues with a patients sedation, they had contacted the service the following day to thank the staff for their care.

Emotional support

For our detailed findings please see the section in the surgery report.

Staff provided emotional support to patients, families and carers to minimise their distress.

The nurses and doctors were very supportive of the patients and we saw that they reassured patients during the procedure.

We spoke with a patient who said that they had been really worried about the procedure beforehand but they said they thought the procedure had gone very well and that the staff were very caring and reassuring during the procedure.

Understanding and involvement of patients and those close to them

For our detailed findings please see the section in the surgery report.

Good

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.

Patients often rang the clinic as they were concerned about the procedure. We saw that the administration staff were very caring, and they would provide step by step assistance if necessary. Staff had delivered the bowel preparation at patients' homes if they had been unable to collect the preparation from the pharmacy.

The doctors gave good explanations about the procedure and we observed that the doctor discussed with the patient why they had been referred for the procedure, what would happen during the procedure, they also described the sedation process.

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

Good

We had not rated this service before. We rated it 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 people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The endoscopy suite was located on the first floor of the building and had access from stairs and a lift. There was an appropriate waiting area for patients and changing rooms for male and female patients with an adjacent accessible toilet. There was a waiting area and then patients were taken into the scoping room and from there to the recovery room.

The changing rooms had lockable lockers for patients' belongings, but the service was trialling bags for patient's belongings so that they could take them with them during the procedure.

Information about chaperones was available in the pre-treatment area and was available in different languages.

There were black out blinds in the scoping room to improve the image quality during the procedure.

All areas of the endoscopy suite were air-conditioned.

The service did not accept patients who had insulin dependent diabetes, any suspected cancer referrals or any patients who were under 18. They would see a patient with a polyp but only if their previous polyp was smaller than one centimetre. They also saw some repeat patients who had Barrett's oesophagus (a condition where the cells of theoesophagusgrow abnormally).

Information about the procedure was sent out with the appointment including fasting instructions. There was also a map and parking instructions. There was information for patients who required sedation about driving and operating machinery 24 hours following the procedure. A prescription for bowel preparation was sent out in the post so that patients could pick this up before their procedure.

There was a range of patient information about all aspects of the procedure. These included information about sedation, symptoms to expect following the procedure and information about levels of discomfort during the procedure. These were available in different languages.

Meeting people's individual needs

For our detailed findings please see the section in the surgery report.

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 treat and discharge patients were in line with national standards.

Patients were referred for procedures by their GP and the consultants triaged all the referrals. Once the patients had been triaged letters were sent out with an appointment. These were confirmed with text messages and telephone calls and a number was left so that patients could ring and speak to a staff member if they wished to do so.

The time slot for a sigmoidoscopy was the same as for gastroscopy. Colonoscopy slot times were double to ensure correct withdrawal times.

In the last three months the service had received 524 referrals of which 24 had been rejected for treatment. A letter was sent to the GP with an explanation about why they had been rejected. For patients referred to the service 99% were seen in six weeks from referral to diagnostic test.

Good

Medical care (including older people's care)

Delays in treatment were usually due to patient cancellations. If a patient cancelled their appointment an exception report was completed. Very few clinics were cancelled and if they were this was due to staffing issues or equipment.

Following the procedure, patients were discharged, and a report was sent to their GP and they were given a copy to take with them. The report was loaded onto the GP record system, including the images, and then the paper copy was destroyed. The service performed very few follow up appointments. The service sent out 95% of reports to the patients GP on the day of treatment.

If a patient missed their appointment they would be rebooked and if they failed to attend again the patient would be discharged back to the GP with an accompanying letter.

Learning from complaints and concerns

For our detailed findings please see the section in the surgery report.

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

Good

We had not rated this service before. We rated it as **good.**

Leadership

For our detailed findings please see the section in the surgery report.

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.

There were clinical directors for each area of the service to provide leadership and clinical support and direction for the services. They worked with the consultants providing the service to further develop the service and to improve quality and patient experience.

The clinical director for the service was lead consultant at a large university teaching hospital and had a range of experience. They told us that the service had been updated since they had been appointed with new equipment and updated pathways and protocols. They said that the chief executive was very supportive of updating the service and that there was a focus on safety and quality.

The clinical director was aware of the value of the service to primary care clinicians and provided support to further develop capacity and competencies amongst primary care colleagues with training sessions and observation of practice.

Vision and strategy

For our detailed findings please see the section in the surgery report.

The service 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 and aligned to local plans within the wider health economy.

The service had an annual plan to develop each clinical area of the service. The plans had been developed with the clinical director of each service.

There was an annual business plan for each area of the service.

Culture

For our detailed findings please see the section in the surgery report.

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.

It was evident that the staff worked well together and that there was a mutual respect for all team members. Staff told us that the culture of the organisation was good and that they wouldn't be afraid to raise concerns if appropriate.

The medical lead said there was a good relationship between them and the clinical director and that they had never been refused anything that they had requested to improve the service. They said they thought that they had been brought in to further develop the service as it developed.

Good

Medical care (including older people's care)

There was good staff development with staff members being trained and developed into roles in the department. Staff had worked there for a long time and there were low sickness and attrition rates.

Governance

For our detailed findings please see the section in the surgery report.

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

There were weekly operational meetings and all clinical areas of the service participated in these meetings. Agenda items included incidents, complaints, safeguarding infection control, and access and flow issues for each service. Following these meetings an action log was produced with actions for individual services to complete. These remained on the log until completed and they were then closed and removed from the log.

There were governance committee meetings every three months with representation from each clinical service. Each service had its own section with issues brought from the weekly operational meetings or from the staff of that particular part of the service. This gave an overview of the services delivered at the location and any issues or risks arising from these services.

The endoscopy team had team meetings to discuss issues affecting their service, they also did feedback about the days procedures after each session

Managing risks, issues and performance

For our detailed findings please see the section in the surgery report.

Each service had a rolling programme of audit. Audits for the endoscopy service included an annual review of referral guidelines, decontamination, scope tracking, environment, water and consent processes. There were also mortality and morbidity audits, histology turnaround and reporting times and onward referral to secondary care.

All the key performance indicators were measured every six months by the service. The clinical director reviewed the performance of all the consultants both in the service and at their trusts so that they could monitor the quality of the service. All the patient outcomes contributed to the Joint Advisory Group for Gastroenterology (JAG) numbers of procedures carried out. They also reviewed any queries from the reporting of the results.

There was a risk register which was reviewed during governance committee meetings. Risks were categorised as either low, moderate or high. There was a description of each risk, risk tolerance, and a description of actions to reduce the risk. It was easy to see when the risks had been reviewed and what action had been taken. Each risk was allocated to a specific person. There were not individual risk registers for each clinical service.

Risk management was an agenda item on the weekly operational meeting agenda. The risk register was updated following these meetings with appropriate risks.

All the consultants worked for organisations that were accredited by JAG.

The clinical director considered the biggest risk was the patients having sedation for their procedure but said that they had put systems and processes in place to reduce the risk as much as they could.

Managing information

For our detailed findings please see the section in the surgery report.

Engagement

For our detailed findings please see the section in the surgery report.

Learning, continuous improvement and innovation

For our detailed findings please see the section in the surgery report.

Good

Surgery

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

Are surgery services safe?

Good

The main service provided by this hospital was surgery. Where our findings on for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We had not rated this service before. We rated it as **good.**

Mandatory training

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

The service used an electronic system to monitor staff completion of mandatory training modules. Staff were automatically emailed when training modules were due to be completed.

Training modules included Mental Capacity Act including consent, adult and children basic life support, cancer awareness, moving and handling, infection control (clinical and non-clinical), domestic violence awareness and dementia awareness.

Information provided by the service showed that 98% of all staff had completed the training modules at an appropriate level.

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.

Over 98% of eligible staff had completed adult and children safeguarding training to the appropriate level.

The service had a safeguarding lead trained to level three (other senior staff had also been trained to this level). The safeguarding lead had links with the local authority safeguarding boards and clinical commissioning groups.

The service provided information to staff about PREVENT strategies and female genital mutilation.

We saw a domestic violence poster in the toilets with contact numbers for help and support.

The service had appointed two safeguarding champions who could signpost staff to the correct policies and give advice about the correct person to speak about a concern.

There were clear safeguarding pathways that were displayed throughout clinical and administrative areas.

Staff understood their safeguarding responsibilities and could provide examples of where they had followed the service's pathway, including a patient that had displayed low mood levels.

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.

All surgical equipment used for minor surgery was single use.

The service was visibly clean and tidy.

The service used disinfecting wipes to clean clinic rooms and there were posters highlighting how and where to use the different types of wipes.

We observed staff adhering to infection prevention controls including handwashing and wearing personal protective equipment.

The service conducted regular hand hygiene audits. The results for the second quarter of the year showed 100% compliance.

We saw hand gel dispensers in the waiting area, clinic rooms and administrative office and we saw staff use these.

Sharps bins were assembled and labelled correctly and were not overfilled.

The service had service level agreements in place for the disposal of clinical and non-clinical waste.

There was a daily cleaning log in each clinic room. These detailed which items needed to be cleaned each day including all medical equipment, computer terminal and patient trolleys. It also required staff to remove clinical, non-clinical and confidential waste.

Whilst the cleaning log in clinic room one was up to date, this was not the case for clinic room two which did not have any entries for December 2019 (we checked with a member of staff who confirmed that the room had been used in December). However, we saw that equipment had "I am clean" stickers dated the day of the inspection.

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.

There were fire extinguishers throughout the premises and these had been tested appropriately. There was also an up to date fire safety certificate displayed in the reception area.

The service had up to date public liability insurance.

There was an accessible toilet on both floors of the premises each with emergency pull cords (a requirement identified at a governance committee meeting earlier in the year).

The service had an emergency trolley in the main corridor which was checked by staff that it contained the right equipment. Weekly checks were recorded of the equipment held on the trolley and a list of when any medication was due to expire. This contained emergency medication for anaphylactic shock (the medicine was within its expiry date) and an oxygen cylinder (which was full). The trolley also contained Resuscitation Council Guidelines (UK) regarding anaphylactic shock and adult basic and advanced life support pathways. There were posters throughout the building highlighting where the emergency equipment was.

Electrical equipment had been calibrated and safety tested. There was a folder in the administrative office which listed when each item had been tested and calibrated.

We saw bleach stored in an unlocked cupboard in a clinic room. We spoke with staff and this was moved back to the locked storage cupboard it should have been kept in. It was noted that the service did not leave patients alone in the clinic room.

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.

There were clear pathways for patients to access the minor surgery service. These included pathways for referral to the service; correspondence between the patient and the service; attending a clinic; and for histology.

The service conducted quarterly minor surgery documentation audits, which included an adapted World Health Organisation surgical safety checklist and consent. The results for both quarter one and two (2019) showed that of ten patient records checked, across 80 different metrics, clinicians had complied with documentation standards on 79 occasions.

We reviewed completed patient records. In one set we saw that the records prior to the surgical procedure included checks on the number and location of cysts to be removed. Of three minor surgery records we reviewed, the surgical safety checklist had been completed.

We observed one minor surgical procedure. Both the consultant and healthcare assistant confirmed the patient details with them and the procedure they were having. They checked whether the patient had any allergies, particularly to anaesthetic, and what medication they were currently taking. The consultant explained the risks and benefits of both having (or not) the procedure.

After the procedure the consultant confirmed that the patient would need to book an appointment with their GP in two weeks' time to have the stitches removed. The patient was given aftercare advice including wound management. The consultant informed the patient that their GP would be able to provide support should they have any issues after discharge.

Patients were given written discharge information on leaving the service including the location and number of stitches, and when these should be removed.

There was no formal training regarding sepsis. However, there were UK Sepsis Trust posters throughout the premises. There was also an information board within the reception area highlighting the signs and symptoms of sepsis to patients and staff. The service also provided an example of when it had recognised that a patient might have had sepsis.

Initial fitness for minor surgery procedures was completed by the patient's GP. The referrals were then triaged by a central team from the clinical commissioning group to check that the patient was suitable for the procedure. The service's minor surgery pathway included a pre-operative check of the referral information and the patient to further check their suitability. The service said that there were rarely any issues with the referrals it received and that the business and communications manager regularly met with the commissioning groups. These meetings were not minuted so we could not verify this.

There were no specific sections on the referral form (received from the central team) to highlight whether a patient had allergies, learning disabilities or autism, or if the patient was living with dementia. However, we saw that this information was contained within the referral text.

Patients with potentially cancerous lesions were not referred to the service but instead to hospital for further checks. However, any patients that the service saw that they suspected of having symptoms of cancer would be referred to a local hospital trust. Data showed that 100% of suspected cancer patients had been onward referred in the first six months of 2019.

Nursing and support 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 staff a full induction.

There was a clear induction process for new starters. The first week included issuing identification badges, having the appraisal process confirmed, updates on the mandatory training and local reporting procedures. Staff then had a formal meeting with their manager after the first month to review their objectives and agree a development plan. A further review was carried out after three months at which point successful staff would complete their probation.

Most nursing and support staff had undergone and annual appraisal.

The service did not use agency staff.

The service had its own "bank" of staff it could use to cope with increased demands.

The service had low sickness absence and staff turnover rates.

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 staff a full induction.

There were ten consultants that provided services to the organisation on a sessional basis under practising privileges.

Each consultant had a clinical review within the first month of starting at the service.

The service did not use locum doctors to provide services.

The service had low sickness absence and staff turnover rates.

The service did not employ any resident medical officers as no patients stayed overnight.

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.

Referrals were received electronically and the details printed ready for clinics. We saw that records were stored securely in the main administration office. Once clinics had been completed, any updated information was scanned onto the patient's electronic record, the paper copy disposed of securely.

Discharge summaries were shared electronically with GPs following patient procedures.

The service aimed to send all discharge letters to GPs within five days of the patient procedure. Audit data for quarter two of 2019-20 showed that of the 30 case notes sampled, all discharge letters were sent to GPs within the required five days (the majority were sent within two days or less).

We reviewed six records which covered various services including endoscopy, minor surgery and ear nose and throat. The records were legible and had been completed appropriately.

Medicines

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

The service had an up to date medicines policy with a review date.

The service had conducted a controlled drugs audit to ensure that it was acting in accordance with the National Institute for Health and Care Excellence guidelines Controlled drugs: safe use and management. The audit showed that the service was complying with all relevant recommendations within the guidelines.

All medicines were prescribed by consultants in line with the relevant national formulary.

The service had received its controlled drugs license from the Home Office.

During the surgical procedure we observed, the consultant checked the expiry date of the local anaesthetic with the healthcare assistant and confirmed the amount to be administered. This was recorded in the patient record.

The service had appointed a Controlled drugs accountable officer who was responsible for all aspects of controlled drugs management within their organisation.

Controlled drugs were stored in a locked cupboard in the endoscopy room. We saw that the appropriate documentation had been completed but there were no sample signatures from the consultants. We raised this during the inspection and the issue was immediately addressed. This shows the authentic prescribers signature when signing controlled drugs out for use.

Controlled drugs were securely locked away, as were the keys, with only registered nurses having access to the keys.

There was a detailed log of prescriptions completed for endoscopy procedures, including laxatives.

There was a medicines fridge in one of the clinic rooms. This was locked. There was also a temperature sensor displaying the current fridge temperature and alarms if the fridge went outside a range of 1 to 8 degrees. There was a log of fridge temperatures and the medicines management policy indicated what actions staff needed to take if the temperatures went out of range. The fridge was used for the storage of local anaesthesia for minor surgery.

Incidents

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 service had both a serious untoward incident policy and an adverse incident policy. These policies covered different types of incident for example clinical incidents or information governance incidents.

The service had not reported any serious incidents in the reporting period.

The service maintained an incident tracker which logged the incident type, details of any actions and learning, and the severity of the incident.

Good

Surgery

We reviewed five incidents that had occurred in the previous 12 months. We found that these were investigated appropriately and action taken where needed (including introducing signs highlighting the location of the emergency trolley).

Incidents were discussed as part of the weekly operations meetings and quarterly governance committee meetings. Minutes from the committee meeting in July 2019 showed that staff had followed all policies correctly and "no further actions were required".

The quality and operational lead reviewed all alerts from the Medicines and Healthcare products Regulatory Agency to see if they were applicable to the service. If they were, they were circulated to the clinical lead for the service for implementation.

The staff we spoke with understood Duty of Candour and when this would apply.

Are surgery services effective?

Good

We had not rated this service before. We rated it 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. Staff protected the rights of patients subject to the Mental Health Act 1983.

The service acted in accordance with various guidelines issues by the National Institute for Health and Care Excellence, and with the Mental Capacity Act.

The service had agreed Commissioning for Quality and Innovation (CQUIN) targets with its commissioners. These targets were designed to demonstrate improvements and innovation in a specified area of care. The service had carried out two CQUIN reports: health inequalities, and patient experience. Whilst the service was not required to carry out these reports, it did so to gain assurance that it was providing effective care and treatment.

The service used a performance scorecard to check whether it was meeting key performance indicators set by the clinical commissioning groups that commissioned its services.

The CQUIN surrounding health inequalities - specifically whether the service was reaching the "most deprived, disadvantaged and marginalised in [the] communities" – highlighted a number of changes the service could make. This included increasing the number of languages that chaperone information was displayed in.

The clinical commissioning group asked the service if it could share the work it had done surrounding the CQUIN for health inequalities with other providers.

Nutrition and hydration

Patients attended only for minor surgery and would leave immediately after the procedure. There were no requirements to check fluid or nutritional intake.

A water cooler was provided for patients in the waiting area.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

We observed one minor surgery procedure which required local anaesthetic. Both the consultant and the healthcare assistant repeatedly checked with the patient the effectiveness of the anaesthetic both before and during the procedure. The patient was given advice to take paracetamol to help with pain relief during recovery. However, there was no formal recording of the patients' pain levels either during or after the procedure.

Patient outcomes

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

The service used a performance scorecard to check whether it was meeting key performance indicators set by the clinical commissioning groups that commissioned its services.

Good

Surgery

We reviewed the performance scorecard and saw that the service was performing well. It had low did not attend rates, saw patients quickly and sent discharge letters in a timely manner to the referring organisation.

The service monitored the referral activity of GP practices to see whether these were increasing or decreasing. If there had been a decrease in referrals from a particular practice, the service would contact it to see whether this was a consequence of the quality of service provided for the patient.

However, the service did not proactively collect data from GPs about any patients that might have returned to their local practice due to concerns about their surgery, including wound infection or management. It could therefore not be assured about the level of patients experiencing post-surgical issues.

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 had a Safer Recruitment policy which set out the mandatory checks required by law, those required by the Department of Health, and those required by the service. Checks included those relating to identity, professional registration and qualifications, references, pre-employment health assessments and Disclosure and Barring Service checks. We saw evidence of this information staff files, including clinical training certificates.

The service had ten consultants working on a sessional basis. Each consultant held a substantive post in an NHS trust. We reviewed five consultant files and saw evidence of up to date professional registrations and appraisals with their NHS appraiser. The service wrote to the consultants' responsible officer every 12 months to update them on any concerns they might have.

All but one staff member had an appraisal in the 12 months prior to the inspection. The standardised appraisal proforma was mapped against the services values of safety, communication, care, respect and learning.

Consultants provided evidence of mandatory training requirements to the service.

Multidisciplinary working

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

Due to the nature of the surgery undertaken, there was little requirement for multidisciplinary meetings. However, there were clinical governance meetings every three months attended by senior staff including the clinical leads for each service, including minor surgery.

There was regular contact with GPs in the area, including educational events run by the service.

Seven-day services

The service was open Monday to Saturday between 8am and 6pm, with minor surgery procedures being carried out primarily on a Thursday.

Health promotion

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

There were numerous leaflets and posters throughout the building providing health information to patients and carers. This included information about bowel cancer awareness, diabetes and blood pressure awareness, and managing asthma and shortness of breath. There were also leaflets about maintaining mental health and smoking cessation.

There were leaflets from UK diabetes charity containing recipes for healthy eating.

There was a "topic of the month" board, which at the time of the inspection included information about sepsis; the signs and symptoms.

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.

Consent and mental capacity formed part of the mandatory training modules for staff and 98% of staff had completed this.

Whilst consent for minor surgical procedures was taken by the referring GP, the service took consent again when patients attended to ensure they understand why they

were having the procedure. Staff could provide examples of where services had not been provided as patients either lacked capacity or where not sure why they had been referred.

We observed a surgical procedure where the consultant had detailed discussions with the patient about the risks and benefits of the surgery, and confirming whether they would like to proceed.

Of the six records we checked we saw that consent had been taken appropriately on each occasions.

Are surgery services caring?

Good

We had not rated this service before. We rated it as **good.**

Compassionate care

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

The service had a privacy and dignity statement with the following sections. Courtesy, honesty and respect for dignity, communication, confidentiality, care and treatment and individual and cultural diversity. This had been updated in July 2019.

There was a sign on the reception desk advising patients that they could discuss their condition in a private room if they felt uncomfortable discussing information in the reception area.

The service collected patient satisfaction information and presented this information quarterly (results were displayed in the reception waiting area). The results for quarter two (2019-20) showed that of 985 patients surveyed, 99% were either likely, or extremely likely to recommend the services to their friends or family.

We saw comments that patients had provided about the service. Patients told the service that "staff were absolutely fantastic" and that they "didn't have to wait long".

We observed staff maintaining privacy and dignity during procedures. Patients could also request chaperones if they wanted.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

We observed one procedure where both the consultant and the healthcare assistant took time to ensure the patient was calm and ready for the procedure. They checked throughout that they were comfortable.

We observed HCA staff reassuring a patient during a surgical procedure.

The service provided a "faith room" and "quiet room" for patients and staff who to access this.

Patient said that the service provided "wonderful customer care" and a "very professional service".

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

We spoke with the partner of one patient having minor surgery. They told us that they had been kept up to date about the appointment date and time and it had run on schedule.

We observed a consultant speaking to both a patient and their partner to discuss the proposed surgical procedure and ensure that they both understood what would happen and how long the recovery time would be. The consultant took time and did not rush the patient when they had a number of questions at the start and end of the procedure.

We spoke with the partner of a patient who told us that they had been kept informed about what was happening regarding the surgical procedure.

The service collected comments from patients and their carers about the service. One patient commented that "the doctor and nurse were extremely nice and put me at ease".

Are surgery services responsive?

Outstanding ☆

We had not rated this service before. We rated it as **outstanding.**

Service delivery to meet the needs of local people

Good

Surgery

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.

The service met with its clinical commissioners to review performance and plan services.

The service worked closely with homeless charities to provided healthcare to homeless people within the communities it served. There was a sign in reception highlighting that the service would "meet your needs whether you have a permanent address or not".

The service had applied to the Charity Commission to set up a charitable foundation to support its work with homeless people.

The service provided war veterans with service-related health conditions, priority treatment unless another patient had clinical priority.

The service had developed and presented at free public health education meetings in the communities it served. The meetings aimed to raise awareness of diabetes and asthma. It had also held education events about bowel cancer, which included information about recognising symptoms, seeking help, and the benefits of bowel screening. Following one of the sessions a local GP had reported an uptake in a health promotion programme. The service had also been contacted by a member of the public via social media thanking the organisation for a session on diabetes and asking if there were more sessions planned.

The service actively engaged with black, Asian and minority ethnic groups to help increase health education and outcomes. For example, it had talked to community groups where there was a higher incidence of diabetes.

There was free parking at the premises.

Reception area contained water cooler for patients. There was also a TV, magazines, and colouring books for children.

There were sofas in the waiting area, and chairs of different heights that made it easier for patients with mobility issues to sit down or stand up.

A number of consultants were multilingual.

Staff asked patients to complete an equality and diversity form. There was a poster by reception informing patients that this information was requested so the service could ensure that its policies were non-discriminatory.

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 service gave examples of where anxious patients had been supported to attend their appointments. This included patients visiting prior to the day of the procedure to look at the premises, clinic rooms and talk to staff about what would happen.

The service gave examples of where they had worked with the patients with learning disabilities and their families to help them access services.

Patients had the choice of a preferred clinic to undergo their procedure.

The service displayed a poster in the waiting area informing women that they "were welcome to breastfeed here".

The service had access to a telephone interpreting service.

Dementia awareness was included within the mandatory training modules.

Whilst it was the responsibility of patients' GPs to remove stitches after surgery, the service gave us an example of when it had removed these for a patient having difficulty seeing their own GP.

The service did not have a hearing loop installed for those patients with hearing impairment.

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 treat and discharge patients were in line with national standards.

Patients received a text message three days before their procedure and the telephone call the day before.

Good

Surgery

Key performance indicators were set by the clinical commissioning groups and monitored by the service.

We reviewed the referral to treatment times for minor surgery procedures. All patients had undergone surgery within 18 weeks of referral (quarter one and two 2019-20).

The service sent 100% of clinical reports (including discharge letters) to the referrer within the targeted two days of the procedure.

The service had a contractual agreement with the hospital providing the histology reports for these to be completed within five to ten days (depending on the urgency). However, more than 60% of reports were taking over three weeks to be returned by the hospital.

The service monitored "did not attend" rates (the target was less than 7.5%). Quarter one (2019-202) had a did not attend rate of 10% (32 patients from a total of 311). Quarter two had a did not attend rate of 7.8% (24 patients from a total of 306).

Patients were given a second appointment if they did not attend their first. Those that did not attend their second appointment were referred back to their GP. This process was set out in the service's Access Policy. However, it also told us that clinicians would review the clinical risk of referring the patient back to their GP rather than taking further steps to contact the patient with a view to them attending. It could provide examples of where it had taken further steps to contact a patient.

Waiting times for minor surgery or outpatient appointments were not displayed within the waiting area. However, during the course of the inspection, patients rarely waited longer than a few minutes to be seen. Those patients attending for endoscopy appointments were advised that they might need to attend for between one and three hours.

There had been 18 cancelled minor surgery procedures (1%) within the 12 months to July2019, 1% of the total number of surgical patients. The service had a cancellation target of less than 5%.

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 and investigated them. However, there was not a clear pathway for sharing lessons with all staff.

The service had a comprehensive complaints policy. This was displayed with the reception area for patients and carers to read.

The complaint policy highlighted the rights of patients to take their complaints to independent adjudicators including the Parliamentary and Health Service Ombudsman (NHS patients) and the Independent Sector Complaints Adjudication Service (private patients).

The service sent us details of the 28 complaints it had received between May and October 2019. Of the 28 complaints received in this period, none related to surgery, 17 related to ultrasound scans, seven to outpatients appointments and four to endoscopy appointments.

The service provided an example of where a complaint had led to changes in service. It told us that following a number of complaints about the ability of patients to contact the service by telephone, it changed its service provider. This led to an increase in activity as more patients were able to contact the service. We saw in the minutes of a meeting that a patient had written to the service praising the way that their complaint had been dealt with.

Of the 28 complaints received, we reviewed five across a number of specialities. We found that the service had responded quickly to these complaints (it met the target of 90% responded to within three days) and kept the complainant updated.

However, it was not always clear how learning was shared throughout the organisation. For example, we saw some evidence in the governance committee meetings that changes had been made to how endoscopy patients were given advice regarding "starving" before procedures. However, another formal complaint involved a lack of communication by staff regarding dissolvable stitches. There was no evidence that learning from this complaint was shared with staff at all levels to help prevent recurrence.

Are surgery services well-led?

Good

Surgery

Requires improvement

We had not rated this service before. We rated it as **requires improvement.**

Leadership

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

Staff told us that senior staff were visible and approachable.

Senior managers told us that they felt they had autonomy in their roles to help develop and influence the services provided for patients.

The service was considering developing an executive board to help provide external challenge and scrutiny.

We saw examples of how staff had progressed through the company to take on more senior roles. Staff told us that they felt supported and encouraged to develop within these leadership roles.

The chief executive (who was also the medical director and minor surgery clinical lead) had attended various leadership programmes both within and outside of the NHS. They also provided mentoring and training to others, and had recently completed a clinical update course.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service's quality account report set out the strategic priorities for improvement for 2020. These included providing accessible, efficient and effective health care services; growth and sustainability; accountable and effective governance; high levels of patient satisfaction; and skilled people, proud of working at the service. The plan set out how the service planned to meet these strategic aims. The strategy was mapped against the contractual obligations set by the service's commissioners.

The service's values were safety, communication, care, respect and learning. Staff adherence to these values were assessed during annual appraisals.

The service's mission, values and vision were displayed on posters throughout the service. The service aimed to "deliver accessible, efficient and effective health care services". Its vision was of "professional excellence in providing safe, timely and appropriate care for patients".

Not all the staff we spoke with were aware of the service's vision or plans for the future with one person telling us that they whilst they knew the service was "doing well" they were "not sure where [the organisation] would be in a few years' time".

There was an equality and diversity strategy and plan for the service.

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.

There was a positive culture at the service, with staff feeling proud to work there.

One member of staff told is that the service had "high standards" and staff "cared about the service". Another told us that the service was a "lovely place to work" and that there was a "really good culture".

The service had a comprehensive whistleblowing policy. However, staff told us that they felt confident to approach managers if they had concerns about their work.

There were low sickness and vacancy rates.

Governance

Leaders had established some governance processes within the service. However, these processes were not always consistently applied to all areas, including

partner organisations. Whilst staff at all levels were clear about their roles and accountabilities, they did not always have regular opportunities to meet, discuss and learn from the performance of the service.

The service had clear governance arrangements. Clinical directors for all specialties attended quarterly clinical governance committee meetings, as did the quality and operations lead, and the chief executive (who was also the medical director).

The service had developed an annual governance plan with a view to further development of its governance structures in order to "support the development and growth of the organisation". The plan set out the annual audit programme and the risk management procedures. The plan also looked at future developments including the introduction of a board of directors "to ensure that explicit and robust accountability arrangements are in place and effective at all levels". The governance plan was aligned to the service's mission, vision and values statement.

The clinical leads monitored daily performance, including attendance rates and referral to treatment times. These were discussed at the joint weekly operations meetings where all clinical leads were present. There were set agenda items for the weekly operations meetings relating to activity; urgent matters; service issues; HR and recruitment; "compliments/ complaints /concerns /Duty of Candour"; and safeguarding and risk management.

The service held a quarterly governance committee meeting with all the clinical leads present. The meeting had agreed terms of reference. This purpose of the committee was, amongst other things, to approve strategies and policies; provide assurance to commissioning organisations that effective clinical governance arrangements were in place; and to review that it was compliant with relevant legislation. There was an agreed general and core membership for the committee.

The service attended an annual monitoring meeting with the clinical commissioning group. The organisations reviewed performance and quality of the individual service provided, finance and contracts.

The service had a comprehensive audit schedule for each of its services including minor surgery, outpatients, ultrasound and endoscopy. The schedule set out which audits needed to be conducted and how often. For example, WHO surgical safety and consent audits were conducted quarterly, whilst "did not attend audits" were conducted monthly.

Guidelines and policies were reviewed every two years or sooner if there had been any national updates. Updates would be discussed during governance committee meetings.

Policies were kept in hard copy within the administrative office, and electronically on a shared drive. Hard copies were also available within the clinical areas.

The business and communications manager conducted unannounced visits of remote sites to carry out observations. They also requested feedback from GPs about the quality of service.

The service had a contract in place for a local hospital to provide histology reports for the clinical specimens the service sent it. Data showed that the hospital was not meeting the key performance indicators for reporting results. The service had a "tracker" in place to monitor how long reports were taking and chase outstanding results.

However, there were no formal contract meetings with the hospital to review, monitor or challenge the hospital's performance.

The service had a system to monitor the competency of the consultants that worked at the organisation. The electronic system provided details of professional registration, indemnity insurance, disclosure and barring service checks and job descriptions. Each consultant should have also provided two references to support the work they carried out.

However, we saw that one consultant had not provided any references, and another had only provided one. This was not in accordance with the service's own Safer Recruitment policy. The service highlighted that the consultants were already know to the chief executive, but it agreed at the inspection to obtain the references and update its systems.

In addition, the chief executive told us that consultants joining the service were not discussed at the clinical governance meeting. They instead went through a formal HR process for standard documentation checks. There was no independent clinical review of their practices prior to their employment, either via the governance committee or

a separate advisory committee. Therefore, the service did not have effective recruitment procedures in place to ensure that it made appropriate checks on consultants prior to them commencing work.

However, we were told that consultant practice was reviewed by the clinical lead for that service shortly after they started.

The service's policy regarding Disclosure and Barring Service checks did not set out how often these checks needed to be reviewed.

The quality and operational lead reviewed all alerts from the Medicines and Healthcare products Regulatory Agency to see if they were applicable to the service. If they were they were circulated to the clinical lead for the service.

There was no formal monitoring of post-surgical complications. Whilst the service rarely saw patients again after minor surgery, it did not actively seek feedback from GPs about whether patients returned to primary care for follow-up treatment or wound infections. The service told us that infection rates were low, but as it did not collect any data, we could not verify this.

There were regular meetings for senior staff and support workers and administrative staff were included in the ultrasound mandatory meetings and endoscopy users group meetings.

Managing risks, issues and performance

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

The service operated a risk register which was reviewed during governance committee meetings. Risks were categorised as either low, moderate or high. There was a description of each risk, risk tolerance, and a description of actions to reduce the risk. It was easy to see when the risks had been reviewed and what action had been taken. Each risk was allocated to a specific person. Risks included the failure of endoscopic decontamination equipment, the management and security of controlled drugs, and the failure of IT services.

Staff met at the weekly operations meeting to discuss various issues. Minutes of the meetings showed evidence of discussions relating to completion of mandatory training, a review of the risk register, visits to GPs to discuss the endoscopy referral process, and new starters to the organisation.

An action log was generated at the end of each weekly meeting. This acted as a record of what had been discussed between the clinical teams and who was responsible for any ongoing or newly generated actions. However, whilst there was an action owner, there were no timescales or target dates for completion, so it was unclear how long actions had been on the log for or when they were due to be completed.

Minutes from governance committee meetings every three months showed discussions between all clinical leads regarding the implementation of new policies, a review of ear, nose and throat referral forms to help reduce delays in onward referrals, and discussions regarding additional clinical training for such issues as venepuncture. There were discussions regarding safeguarding concerns, complaints and incidents and training rates. There were also updates from local commissioners, and discussions about performance, including "did not attend" rates.

The quarterly clinical governance meeting contained an action log. Whilst the log contained details of the action to be taken and the person responsible, there was no target date for the action to be closed.

The service only carried out minor surgical procedures, so there was rarely the need to discuss new practices. However, if necessary, these would be discussed in the clinical governance meeting. The quality and operational lead reviewed all alerts from the Medicines and Healthcare products Regulatory Agency to see if they were applicable to the service. If they were they were circulated to the clinical lead for the service.

The service used a Quality Risk Stratification Tool, which covered all the services it provided. This was an assessment of whether the service was compliant with certain requirements. The tool contained an action plan to highlight what improvements could be made. Improvements included updating the clinical audit policy, updating complaint leaflets and completing a Workforce and Race Equality Standard report.

The ultrasound clinical governance lead monitored any changes of practice in this area and updated the procedure handbook where necessary.

The service met with clinical commissioning groups covering the Manchester and Preston regions every quarter. They discussed contractual key performance indicators.

The service had local safety standards for invasive procedures (LocSiPP) in place. The aim of the LocSiPP was to "ensure patent safety is maintained" using various processes including standardised documentation, and the use of best practice documentation including the World Health Organisation surgical safety checklist. The service's quality and operations lead was responsible for the implementation and monitoring of LocSiPPs which was checked using various audits.

The service told us that finance did not dictate the work it did. It could provide examples of when patients, referred to the service inappropriately, had not be operated on (following discussions between the consultant and the patient).

The service had a business continuity plan which contained key contact information and what action to take in the event of different scenarios.

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.

There was a policy for General Data Protection Regulation (GDPR) and there were GDPR leads in the organisation. The service completed an annual data protection toolkit and part of the requirement was to have system testing in place which was completed on an annual basis along with maintaining a register of system access users to ensure access to systems is restricted to an individual's relevant work areas only. All staff completed GDPR and records management training as core modules within the mandatory training programme.

The service had a contract with a third party supplier for the disposal of confidential waste.

The service had a comprehensive audit programme to collect data about the services it provided and used this to help it improve.

Information was sent to GPs via secure NHS email addresses. The service used only one central email address to send information to GPs as this enabled them to better review what had been sent and when – this was particularly important if a GP practice challenged the service about when a report had been sent.

There were numerous posters throughout the administrative officer reminding staff about their responsibilities to protect information. This included not leaving computers unlocked if they left their desk and securing patient identifiable information before they left the office for the day.

Engagement

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

The service had good links with local GPs. It offered secondments to GPs to help them gain experience of the work the service provided. The service also provided work experience opportunities to A-Level students.

The service had developed an equality and diversity report in 2017 to ensure it was complying with meeting its statutory obligations under the Equality Act 2010. The service reviewed the demographics of the communities it served. This helped it in its commitment to "developing an organisational culture that promotes equality and diversity in all services … for both our patients and our staff". In its recent quality account report, the service highlighted that "Owing to the recent growth of the Organisation, changes to the current infrastructure mean we now need to revisit our (workforce race equality standard) and this is planned for early 2020".

The service was a Disability Confident Employer (a voluntary scheme set up to identify those companies that were committed to helping disabled people into employment).

We observed reception staff asking patients to complete a patient feedback form at the end of the appointment and

an equality and diversity form. There was also a poster on the exit to the premises reminding patients to complete the form and provide feedback on the service they had received.

The service operated a "you said we did" model for acting on patient feedback. Following feedback from patients, it provided more paper towels in clinic rooms, and clearer directions to patients attending the clinic for the first time.

We saw some examples of staff engagement, including a group fitness challenges.

There had been away days for the senior team to discuss the plans for the organisation. However, there had been no similar activity for staff at other levels within the organisation.

The service worked with local schools to provide work experience opportunities to pupils from disadvantaged areas.

The service had carried out a number of GP education programmes throughout the year to provide support and advice on a number of conditions such as iron deficiency anaemia. These sessions also provided an opportunity for GPs to feedback on the service.

The last annual staff survey showed that 92% of staff were either extremely likely or likely to recommend us to friends and family; 92% of staff felt valued and supported; and 96% of staff stated that they were encouraged to work as part of a team with shared objectives.

There was no staff newsletter or intranet to readily share high level information about the organisation to all staff, including those based at different sites within the group.

Patient feedback was linked to individual clinics so the service could tell whether there were any themes or trends related to a particular service.

There was an organisation chart on the entrance to the waiting area with the names and photographs of staff members.

The service had recently met with 20 GPs from the region to provide education on the endoscopy service provided.

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.

We saw examples of where the organisation had made changes to improve services for patients. A "did not attend" project identified that communities with high population of patients that spoke English as a second language who might not always have understood the reason their GP referred them to the service. Some female patients also wished to be seen by a female clinician. The service provided greater access to female clinicians, and assigned staff with different speaking skills to call patients to explain the referral and appointment. The project led to a decrease from 17% to approximately 7%.

The service was in the process of registering its own charitable foundation. The key priorities were to reduce health inequalities, advise the public on preventing illnesses, and creating a healthy society. The foundation included various healthcare practitioners including GPs, consultants, community nurses and medical students.

The service provided examples of improvements to its pathways from working with its health partners. For example, the referral form for ultrasound scans was altered to ensure that the part of the patient to be scanned was clearer.

The business and communications manager had introduced a call recordings system which helped respond to certain complaints and also for training purposes.

Good

Outpatients

Safe	Good
Effective	
Caring	
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

We had not rated this service before. We rated it as **good.**

Mandatory training

For our detailed findings please see the section in the surgery report.

Safeguarding

For our detailed findings please see the section in the surgery report.

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.

For our detailed findings on cleanliness, infection control and hygiene please see the section in the surgery report.

The outpatient service conducted its own decontamination audit regarding the decontamination of nasopharyngoscopes (a tube inserted through the nose to obtain a view of the space above the soft palate at the back of the nose) prior to the start of clinics. There was 94% compliance with using traceability labels and patient identifiers in the decontamination log, and 88% compliance with traceability labels in the medical records (16 records sampled in the second quarter of 2019). The audit confirmed that “the correct process has been reiterated to [staff] who have not adhered to the correct procedures”. An action plan was not available in relation to areas of non-compliance.

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.

For our detailed findings please see the section in the surgery report.

Staff had access to an emergency trolley in the main corridor which was checked by staff to ensure that it contained the right equipment. Weekly checks were recorded of the equipment held on the trolley and a list of when any medicines were due to expire.

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.

For our detailed findings please see the section in the surgery report.

Patients were referred to the service by GPs using the choose and book system. They were triaged by the commissioner’s central booking team.

The service had a clear pathway for patients to be referred, registered and to be seen in an outpatient clinic.

The service had a process in place to ensure the referrals it received via the choose and book system were appropriate.

Patients did not wait long to be seen by a consultant.

The service had a protocol and pathways to follow if a patient required referring on to secondary care.

We saw an example where a consultant had arranged for a service to book an urgent appointment for a patient.

Nursing and support 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 staff a full induction.

For our detailed findings please see the section in the surgery report.

As of August 2019, the outpatient and diagnostic imaging department had 4.0 registered nursing staff and 8.2 full time equivalent health care assistants. The staffing rotas within outpatients were planned based on a ratio of one nurse to two healthcare assistants. This gave some flexibility across the service and there was cover for annual leave and sickness if necessary. Staff told us that they received a comprehensive induction when they started. From December 2018 to August 2019 there was no use of agency or bank registered nursing staff. The use of bank and agency healthcare assistants had decreased. Between September 2018 to August 2019 this had decreased from 30% to 5%.

From September 2018 to August 2019 staff sickness varied from 18% to 0%. There were no unfilled shifts in the three months of June, July, August 2019.

One per cent of outpatient health care assistants left the service between September 2018 and August 2019, no nursing staff left.

At the time of this inspection there were no vacancies for nursing or health care assistants in outpatients or diagnostic imaging.

Medical staffing

For our detailed findings please see the section in the surgery report.

The outpatient services were consultant led and there were five consultants as well as the clinical director of the service.

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.

For our detailed findings please see the section in the surgery report.

Information gathered during clinics were dictated by consultants and saved to the patient's electronic record. The dictation was typed by a pool of medical secretaries and sent to patient and their GP. Discharge letters were email to GPs.

Records for clinics were kept securely in the administration department prior to being given to the consultant on the day of the clinic. All clinic information was scanned onto the electronic patient record and clinic notes safely disposed of in a confidential waste bin.

The clinic reported that 100% of patient records were available for consultant appointments.

The medical secretaries were up to date with the typing of clinic records. The service had a target of sending out at least 95% of discharge letters to patients and their GPs within three days. The service was achieving a rate of 98%.

Medicines

For our detailed findings please see the section in the surgery report.

Incidents

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.

For our detailed findings please see the section in the surgery report.

All clinical, non-clinical, and administrative staff we spoke with were aware of the incident reporting process in place. There was a low number of incidents reported. The outpatient and diagnostic imaging service had seven

Good

Outpatients

clinical incidents between July 2018 and June 2019. There were four non-clinical incidents in the outpatient and diagnostic imaging service during the same period. These were categorised as either low harm or no harm.

Are outpatients services effective?

We do not rate this domain.

Evidence-based care and treatment

For our detailed findings please see the section in the surgery report.

The service worked to guidance from the National Institute of Health and Care Excellence (NICE) and the appropriate Royal Colleges.

The service had worked with local GP's and put on training sessions to implement NICE guidance on sudden hearing loss.

The clinical lead for the service was responsible for the implementation of new guidance and updates. They wanted to standardise pathways and procedures in primary care across the health economy.

Patient outcomes

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

The service had a performance dashboard it used to monitor key performance indicators set by the clinical commissioning group. These indicators included referral to treatment times, the quality of the letters to GP's, audits of scopes, did not attend rates and clinic cancellations. Performance for the outpatient service was discussed in the weekly operations meetings, and the clinical governance meeting held every three months.

Between April 2019 and November 2019, the service sent, on average, 96% of reports to referrers within five days (against a target of 95%).

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.

For our detailed findings please see the section in the surgery report.

GP's often visited outpatient clinics to observe the clinical sessions and to gain work experience.

Multidisciplinary working

For our detailed findings please see the section in the surgery report.

Seven-day services

The organisation did not operate a seven-day outpatient service.

Health promotion

For our detailed findings please see the section in the surgery report.

Consent and Mental Capacity Act

For our detailed findings please see the section in the surgery report.

Of the six patient records we reviewed, two related to outpatient clinic appointments. We saw that consent for further procedures, including gastroscopy, had been recorded appropriately.

Are outpatients services caring?

We had not rated this service before. We did not have sufficient evidence to rate outpatients at this inspection.

Compassionate care

For our detailed findings please see the section in the surgery report.

Emotional support

For our detailed findings please see the section in the surgery report.

Understanding and involvement of patients and those close to them

For our detailed findings please see the section in the surgery report.

Are outpatients services responsive?

Good

Outpatients

Good

We had not rated this service before. We rated it 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 people and the communities served. It also worked with others in the wider system and local organisations to plan care.

For our detailed findings please see the section in the surgery report.

The consultants described how they had supported patients who needed funding for specialist services from the clinical commissioning group (CCG). An example of this was a patient who required an upright magnetic resonance imaging scan. The consultant had contacted the CCG to support the patient's application.

Meeting people's individual needs

For our detailed findings please see the section in the surgery report.

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 treat and discharge patients were in line with national standards.

The service saw approximately 300 to 400 patients a month for outpatient appointments.

The service worked well with consultants to ensure that a suitable number of appointment slots were available. For example, in February 2019, the service made available almost 500 slots to deal with patient demand.

Slots were scheduled well in advance and made available for the central booking team at the clinical commissioning group to populate.

Once a patient had their appointment confirmed by their GP via the choose and book system, they received a confirmation call from the service 48 hours prior to the appointment with a follow up text reminder to help avoid non-attendance.

We saw that 95% of reports were sent to GP's in five days which met the target set by the CCG's from April 2019 to December 2019 and that all referral to treatment targets were met in the same time period. The did not attend rates were under 10% for the first appointment in the same time period.

The CCG's required exception reports for any measures that were 10% above target.

The consultants told us that very few patients required follow up due to the effectiveness of the triage process and the referral criteria.

The service carried out a number of audits specific to outpatients. These included such things as referrer feedback, GP letter turnaround times and onward referral turnaround times.

Learning from complaints and concerns

For our detailed findings please see the section in the surgery report.

Are outpatients services well-led?

Good

We had not rated this service before. We rated it as **good.**

Leadership

For our detailed findings please see the section in the surgery report.

There were clinical directors for each area of the service to provide leadership and clinical support and direction for the services. They worked with the sonographers providing the service to develop the service and to improve quality and patient experience.

The clinical director told us that they observed other consultants practice in clinic to support their appraisals and one to one's.

The clinical director told us that they had a good relationship with the chief executive of the service and that they were all working to develop the service for the future.

Vision and strategy

Good

Outpatients

For our detailed findings please see the section in the surgery report.

The service had an annual plan to develop each clinical area of the service. The plans had been developed with the clinical director of each service.

There was an annual business plan for each area of the service and the clinical lead and the consultants were keen to further develop the service to support primary care colleagues. The clinical lead said that the service would help to support new ways of working and to bring about change. It would also help to standardise pathways and procedures across the health economy.

Culture

For our detailed findings please see the section in the surgery report.

There was a good culture in the department with staff working together. Staff said that they liked working for the service.

Governance

For our detailed findings please see the section in the surgery report.

There were weekly operational meetings and all clinical areas of the service participated in these meetings. Agenda items included incidents, complaints, safeguarding infection control, and access and flow issues for each service. Following these meetings an action log was produced with actions for individual services to complete. These remained on the log until completed and they were then closed and removed from the log.

There were governance committee meetings every three months with representation from each clinical service. Each service had its own section with issues brought from the weekly operational meetings or from the staff of that particular part of the service. This gave an overview of the services delivered at the location and any issues or risks arising from these services.

The clinical director of the service had developed an email that they sent out every month to all the ear nose and throat consultants with audit results, patient feedback and any issues arising relevant to the service. They encouraged feedback and so could use this information in the governance committee meetings.

Managing risks, issues and performance

For our detailed findings please see the section in the surgery report.

There was a risk register which was reviewed during governance committee meetings. Risks were categorised as either low, moderate or high. There was a description of each risk, risk tolerance, and a description of actions to reduce the risk. It was easy to see when the risks had been reviewed and what action had been taken. Each risk was allocated to a specific person. There was not a risk register for each individual clinical service.

Risk management was an agenda item on the weekly operational meeting agenda. The risk register was updated following these meetings with appropriate risks.

There was an ongoing audit schedule for each service, the audits for the ear nose and throat out patient service included referrer feedback, decontamination audits, patient satisfaction, GP letter turnaround time and onward referral turnaround times.

Managing information

For our detailed findings please see the section in the surgery report.

Engagement

For our detailed findings please see the section in the surgery report.

Learning, continuous improvement and innovation

For our detailed findings please see the section in the surgery report.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

We had not rated this service before We rated it as **good.**

Mandatory training

For our detailed findings please see the section in the surgery report.

Safeguarding

For our detailed findings please see the section in the surgery report.

The sonographers were all aware of all aspects of female genital mutilation as some of them were involved in trans vaginal scanning. They would make the safeguarding lead for the organisation aware if they had any concerns.

Cleanliness, infection control and hygiene

For our detailed findings please see the section in the surgery report.

Each clinical room had appropriate personal, protective equipment available, this was plentiful. There were clinical waste bins with colour coding for disposal of clinical waste.

The healthcare assistant in each clinic was responsible for the cleaning of the probes and these were traceable for each patient. There were hand hygiene and infection control audits for the service that were carried out every three months.

There were processes in place for the cleaning of the probes including the transvaginal probes. The service used appropriate cleaning methods for the probes.

Environment and equipment

For our detailed findings please see the section in the surgery report.

The ultrasound machines were new, and the lead sonographer had worked with several companies to ensure that they purchased the right machines for the service. Staff said the machines were good and the image quality was excellent. The machines were light and portable as they could be used in different locations.

There were service contracts in place for the ultrasound machines and we saw an inventory of equipment with service dates and due dates.

Assessing and responding to patient risk

For our detailed findings please see the section in the surgery report.

The sonographers used “pause and check” before they commenced any scan and confirmed the patients name and date of birth. They checked with the patient why they thought they had come for the scan.

If an unexpected finding was identified on the ultrasound scan the patients GP was contacted. Staff also told us that they occasionally found a deep venous thrombosis and these patients were sent to the urgent and emergency care department of the local trust.

Staffing

For our detailed findings please see the section in the surgery report.

Good

Diagnostic imaging

There were 13 sonographers who worked in the department, some were full time, and some were part time. This gave flexibility and there was cover for annual leave and sickness if necessary. Staff told us that they received a comprehensive induction when they started.

Medical staffing

For our detailed findings please see the section in the surgery report.

The service was supported by a clinical lead who was a consultant radiologist.

Records

For our detailed findings please see the section in the surgery report.

All ultrasound scan results were stored electronically and were password protected.

Images were linked to reports and referral documentation showed any previous reports and associated images.

The scanning equipment recorded the name of the patient, the sonographer and showed that a chaperone was present. They also recorded the time the report was done.

Images could be transferred to other providers using a radiological information system (RIS). This is a system for managing clinical imaging and associated data.

Referrals to and results from the mobile scanning units were sent to a dedicated secure email address. Results and letters were then forwarded to the patients GP or to the relevant service at the clinic.

Medicines

For our detailed findings please see the section in the surgery report.

Incidents

For our detailed findings please see the section in the surgery report.

Are diagnostic imaging services effective?

We do not rate this domain

Evidence-based care and treatment

For our detailed findings please see the section in the surgery report.

The service worked with guidance from the Royal Colleges and the British Medical Ultrasound Society.

The clinical lead for ultrasound was a consultant radiologist. They had worked with the lead sonographer to develop protocols for each scan delivered by the service. This gave consistency to the scans and the reporting of any findings.

Nutrition and hydration

For our detailed findings please see the section in the surgery report.

Pain relief

For our detailed findings please see the section in the surgery report.

Patient outcomes

The service had a rolling programme of audits, these included referrers feedback, patient satisfaction, scan quality of imaging and reporting, rescan for clinical and non -clinical reasons, vetting of referrals and refer backs, reporting times to referrer, referral to scan waiting times, did not attend audit and report to correct referrer.

There was a peer review for every sonographer so that at least 5% of their images were checked. Each sonographer worked within their scope of practice.

The clinical lead reviewed images if there was any need for a second opinion or any major discrepancies as necessary.

Any soft tissue lumps that were scanned were audited to exclude the possibility of sarcoma.

Competent staff

All the sonographers were registered with the Health Care Professions Council and most worked for local NHS trusts. They were all part of the British Medical Ultrasound Society (BMUS) which is a voluntary register for sonographers.

The competence of each sonographer was checked by the lead sonographer.

Good

Diagnostic imaging

All the sonographers had a peer review every month with the lead sonographer, they also had an annual appraisal. Sonographers were assessed for their clinical skills and competencies and their communication skills. If they were considered unsuitable for the service, their contracts were not renewed.

The lead sonographer had their appraisal done by the clinical lead.

Sonographers shared any unusual findings and used these as learning points. They worked together and asked each other's opinion if they were unsure of anything.

The service ran education days and events for sonographers and GP's.

Multidisciplinary working

There was good multidisciplinary working between the sonographers and the health care assistants

Seven-day services

The organisation did not operate a seven-day diagnostic service. They worked over six days but could be flexible and would put on additional clinics if necessary.

Consent and Mental Capacity Act

For our detailed findings please see the section in the surgery report.

Are diagnostic imaging services caring?

Good

We had not rated this service before We rated it as **good.**

Compassionate care

For our detailed findings please see the section in the surgery report.

We saw that staff were caring and treated patients with dignity and respect.

The service had a rolling programme of audit that included patient satisfaction, privacy and dignity and aftercare.

The patient satisfaction surveys were one document, but patients could give feedback on individual services.

We observed two scans as part of the inspection. Staff introduced themselves to patients and after the patient had entered the room staff locked the door so that nobody else could enter. They pulled the curtain across the door to ensure privacy and dignity was maintained. There was always a health care assistant with the sonographer in the scanning room, so patients were never on their own with a sonographer.

Patients were asked when their appointment was booked if they wanted a male or a female sonographer. We heard staff asking patients when they booked their appointment and patients we spoke with confirmed that they had been asked if they required a male or female sonographer.

We saw that staff made patients comfortable before the scan started and checked with the patients throughout the scan.

We spoke with a patient before and after their scan, they said that the booking and arranging of the scan had been very prompt and they had waited less than a week for their appointment. It was on a day that suited them Following the scan they were happy with how it had gone said that the staff were very friendly.

Emotional support

For our detailed findings please see the section in the surgery report.

The health care assistant supported the patient during the procedure ensuring that they were comfortable and supporting them in getting on and off the couch and acted as a chaperone.

Understanding and involvement of patients and those close to them

The service had a "you said, we did" for patient satisfaction. Patients had requested more wipes and tissues following their scan and additional wipes and tissues had been put into each of the clinical rooms. The outcomes of the you aid we did were displayed around the hospital.

We saw that staff gave good explanations of the scan and why the patient had been referred before the scan was started. Following the scan patients were told the outcome of the scan and could ask any questions.

Good

Diagnostic imaging

Staff gave an example where they had found a patient had a deep venous thrombosis and they had sent them to the urgent and emergency care department at the local NHS hospital. The patient had rung back to thank them.

Are diagnostic imaging services responsive?

Good

We had not rated this service before. We rated it as **good.**

Service delivery to meet the needs of local people

The service ran from 8.00am to 8.30pm Monday to Friday though additional clinics could be provided to meet demand.

The diagnostic service provided non obstetric ultrasound services to patients referred to the service. There were referral criteria and referrals were mainly for abdominal, gynaecological and musculoskeletal scans. They did not scan thyroids, breasts, patients under 18 years of age, no patients with post-menopausal bleeding and no patients who were on the two week cancer pathway.

The time slots for scanning were for 15 minutes and double slots were allocated for more than one body part.

Patients could be referred to a mobile diagnostic scanning service for magnetic resonance imaging and computed tomography services. The mobile unit parked on the car park on Saturdays and Sundays every other weekend. The service was provided by a different provider and so was not included in the scope of this inspection.

Meeting people's individual needs

For our detailed findings please see the section in the surgery report.

Access and flow

Clinics usually ran to time but if the clinics were running late the receptionist informed the patients when they booked in for treatment.

Audits for the service included reporting times to referrer, referral to scan times, a did not attend audit and reports to the correct referrer.

Patients were usually scanned in the week that they were referred, and the report was sent to the patients GP the same day or the day after. We observed in the clinic that the sonographers wrote the report immediately after they had seen the patient.

There was a tracker for the scans from the mobile scanning unit, if a patient was seen at weekend then the scan was reported on the following week. Results were disseminated to the referring practitioner.

Learning from complaints and concerns

For our detailed findings please see the section in the surgery report.

Are diagnostic imaging services well-led?

Good

We had not rated this service before We rated it as **good.**

Leadership

For our detailed findings please see the section in the surgery report.

There were clinical directors for each area of the service to provide leadership and clinical support and direction for the services. They worked with the sonographers providing the service to develop the service and to improve quality and patient experience.

The lead sonographer told us that they had a good relationship with the clinical director of the service. They had recently been appointed and had experience of working in the NHS, They had done some work to improve the audit programme and to implement the appraisal process and peer review. Staff told us that they had made a difference since they came.

Vision and strategy

For our detailed findings please see the section in the surgery report.

The service had an annual plan to develop each clinical area of the service. The plans had been developed with the clinical director of each service.

Good

Diagnostic imaging

There was an annual business plan for each area of the service. The lead sonographer was keen to develop the service further

Culture

For our detailed findings please see the section in the surgery report.

There was a good culture amongst the sonographers and the health care assistants who worked with them. All the staff we spoke with told us that they liked working there.

Some staff told us that they were being developed by the organisation and that they felt valued by the organisation.

Governance

For our detailed findings please see the section in the surgery report.

The lead sonographer held monthly meetings with the sonographers, we saw that they had discussed new guidance and other clinical issues. The outcomes of these meetings fed into the governance meetings.

There were weekly operational meetings and all clinical areas of the service participated in these meetings. Agenda items included incidents, complaints, safeguarding infection control, and access and flow issues for each service. Following these meetings an action log was produced with actions for individual services to complete. These remained on the log until completed and they were then closed and removed from the log.

There were governance committee meetings every three months with representation from each clinical service. Each service had its own section with issues brought from the weekly operational meetings or from the staff of that particular part of the service. This gave an overview of the services delivered at the location and any issues or risks arising from these services.

Managing risks, issues and performance

For our detailed findings please see the section in the surgery report.

There was a risk register which was reviewed during governance committee meetings. Risks were categorised as either low, moderate or high. There was a description of each risk, risk tolerance, and a description of actions to reduce the risk. It was easy to see when the risks had been reviewed and what action had been taken. Each risk was allocated to a specific person. There was not a risk register for each individual clinical service.

Risk management was an agenda item on the weekly operational meeting agenda. The risk register was updated following these meetings with appropriate risks.

Each service had a rolling programme of audits, these included referrers feedback, patient satisfaction, scan quality of imaging and reporting, rescan for clinical and non -clinical reasons, vetting of referrals and refer backs, reporting times to referrer, referral to scan waiting times, did not attend audit and report to correct referrer.

All services participated in the weekly organisational meeting and they could bring any concerns or issues to the meeting. There was an action log following the meeting and any risks identified were added to the risk register. They were closed when they were completed.

Managing information

For our detailed findings please see the section in the surgery report.

Engagement

For our detailed findings please see the section in the surgery report.

Learning, continuous improvement and innovation

For our detailed findings please see the section in the surgery report.

Outstanding practice and areas for improvement

Outstanding practice

- The service had carried out a detailed project into why patients did not attend appointments. This outcome of the project led to significantly more patients attending appointments.
- The service had carried out a number of initiatives to improve access to its services for a number of communities and for homeless people.

Areas for improvement

Action the provider MUST take to improve

- The service must follow its Safer Recruitment Policy and must ensure that new consultants are discussed with all relevant staff before being taken on by the service.

Action the provider SHOULD take to improve

- The service should consider updating it Disclosure and Barring Service policy to included guidance for how often checks of existing employees should be conducted.
- The service should ensure that hazardous substances are locked away in their designated area.
- The service should include record a formal assessment of pain during minor surgical procedures.
- The service should consider developing ways to monitor and audit post-surgical complications.
- The service should consider how it shares learning from complaints to ensure that all relevant staff are kept updated.
- The service should look to develop its action logs to include timescales for completion, for example regarding the decontamination audit.
- The service should have a hearing loop for patients with hearing impairments.

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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider did not have effective recruitment and selection procedures in place to ensure that they made appropriate checks on employees.** Regulation 19 (2)