Emersons Green NHS Treatment Centre

Quality Report

The Brooms
Emersons Green
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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

Summary of findings

Letter from the Chief Inspector of Hospitals

Emersons Green NHS Treatment Centre is an independent hospital, owned by Care UK, contracted to provide treatment for NHS patients free at the point of use.

The treatment centre provides surgery, outpatient and diagnostic imaging services for the following specialities: ophthalmology, oral surgery, ear, nose and throat, general surgery, orthopaedics, gynaecology, urology and endoscopy.

Admission to the treatment centre for surgery follows strict referral criteria for people aged 16 years and over who require routine surgery.

There is an outpatient department within the treatment centre for routine pre- and post-operative appointments.

The treatment centre has an inpatient ward with 33 bed spaces. There are four operating theatres, one minor procedure room and two anaesthetic induction rooms, operating Monday to Saturday.

We carried out a comprehensive announced inspection of Emersons Green NHS Treatment Centre on 30 and 31 March 2016, and an unannounced inspection on 11 April 2016.

We inspected the following two core services:

• surgery

• outpatients and diagnostic imaging.

The overall rating for this service was good.

Our key findings were as follows:

Are services safe?

By safe, we mean that people are protected from abuse and avoidable harm.

- There was a good incident reporting culture amongst staff, which was reflected in the consistent numbers of incidents reported in the hospital between October 2014 and September 2015. Learning from serious incidents and root cause analyses was shared with the whole Care UK organisation.
- Staff were aware of the principles of the duty of candour and were open, transparent and apologetic to patients when things went wrong.
- The treatment centre was visibly clean and staff followed infection prevention and control protocols.
- Staff were aware of their roles and responsibilities in reporting a safeguarding concern and knew how to go about this process. Safeguarding policies and procedures were readily available and up to date.
- There were good numbers of staff employed, with relevant skills, that kept people safe from avoidable harm. These levels were regularly reviewed to ensure changes in demand were adequately staffed.
- The design of the treatment centre kept people safe at all times, with waiting areas free from obstructions and providing staff with good visibility of patients.
- There was a good process for monitoring controlled drugs and breakages, including unannounced inspections of controlled drugs log books.
- Patients who deteriorated were well supported by staff. Clear processes existed to ensure rapid and safe transfers to a local NHS acute hospital if needed.

Summary of findings

- We found out of date equipment stored on the ward.
- Incident reporting data had identified a trend in poor reporting of patient allergies prior to October 2015. However, actions had been put in place and allergy reporting had improved.
- The hospital identified a need for better communication between consultants and a clear system to flag urgent referrals.
- The diagnostic imaging department only had one X-ray cassette reader, which would mean there would not be an on-site X-ray service if it broke down.
- The hospital target of 90% compliance with mandatory training in January 2016 had not been met in outpatients or physiotherapy. In diagnostic imaging only 80% of staff had completed basic or intermediate life saving training.
- We saw sediment on a patient water dispenser, and staff did not know if flushing of the dispenser took place, and could not produce any records of this.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- An evidence-based enhanced recovery programme was used for patients undergoing hip or knee replacements.
- The treatment centre scored better than the England average in its hip replacement and varicose vein surgery for the reporting period October 2014 to September 2015.
- Staff were qualified and had the skills to carry out their roles effectively, with a variety of internal training provided by speciality consultants.
- There was good multidisciplinary team working across all departments to ensure effective patient care.
- Discharge planning was started early at the pre-operation stage, including follow-up appointments and organisation of continuing care packages.
- The use of best practice was evident throughout the treatment centre.
- Staff felt their training was good and provided them with the necessary skills and knowledge to perform their role.
- Diagnostic imaging was available seven days a week to inpatients within the hospital.
- The outpatient department provided evening and weekend clinics in all specialities.
- The hospital used approved national surveys to capture patients' outcomes, including the use of a dedicated survey for patients with learning difficulties.
- Diagnostic imaging staff did not always follow up urgent results with GPs.
- Computer systems used to store images and reports were different throughout the Care UK diagnostic imaging centres and other NHS trusts. This meant images had to be sent over to the computer and transferred by a staff member to the patients' electronic folder. We were told images were not always readily available because this was not always done.
- The electronic patient record system was prone to slow down, and the hospital had identified a risk should it stop working completely.

Are services caring?

By caring, we mean that staff involve and treat patients with compassion, dignity and respect.

Summary of findings

- All the feedback we received from patients about the service was continually positive. Patients felt they were treated with dignity and respect and valued their interactions with staff.
- All staff demonstrated genuine compassion for the people in their care, which was embedded into the culture of the departments.
- Patients told us their family were involved as partners in their care. Patients felt able to raise questions and concerns and felt they were always responded to in a positive way and received information in a way they could understand.
- Patients were seen as individuals and care was tailored to them, and explained clearly at each step of the way.
- All patients were given a 24 hour contact number based in the hospital to call at any time if they were concerned about any aspect of their care or condition.
- When care fell short of a patient's expectations, senior managers were quick to engage with the patient to find a solution.

Are services responsive?

By responsive we mean that services are organised so they meet people's needs.

- The treatment centre worked with local Clinical Commissioning Groups, GPs and the patient forum group to plan and develop services for the local population.
- Services were flexible to meet the needs of the population and planned to ensure continuity of care from department to department.
- The hospital took all complaints seriously and investigated them. Where possible, managers offered face to face meetings with patients to discuss their concerns.
- The hospital was meeting all of its referral to treatment standards. All waiting times for a first appointment were six weeks or less.
- The hospital was improving relationships with GPs in the community to understand reasons why referral rates had declined towards the end of 2015.
- The hospital used a pager system to alert patients when they were ready to go through to the clinic, and identified patients this was not appropriate for.
- Staff monitored and audited the length of time patients spent in each department during their journey through the clinics using a traffic light computer system.
- Staff volunteered to put on extra lists to help treat a group of patients from Wales. The treatment centre provided a coach to bring all the patients to the hospital and provided food for all patients.
- Where treatment or care had to be delayed or cancelled, the hospital supported patients and fully explained the reasons why and what would happen next.
- Patients who had additional needs, such as those with learning difficulties, were offered extra support such as longer clinic appointments, and pre-procedure experience visits along with their relatives or carers.
- The hospital did not have sufficient parking for all of its patients, and a patient told us their partner had missed their consultation because they could not park.
- Not all staff were aware of the electronic flagging system for patients with additional needs.

Are services well-led?

Summary of findings

By well-led, we mean that the leadership, management and governance of the organisation, assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- The treatment centre had a challenging, yet achievable, vision and strategy that staff were aware of and involved with achieving.
- Work was actively ongoing with external stakeholders to help deliver the vision and strategy, and to provide the best service for patients.
- The senior management team were an enthusiastic, committed team delivering safe, patient centred care. Staff and patient engagement was embedded in the culture at the treatment centre.
- There were strong governance processes at all levels in the treatment centre, with a monthly quality assurance meeting attended by all clinical and non-clinical staff, as well as the patient forum.
- Staff told us they felt very well supported by their immediate line managers, the divisional management team and the executive team.
- The diagnostic imaging department was working towards achieving accreditation with the Imaging Service Accreditation Scheme.
- There was a strong culture of openness and transparency.
- The vast majority of staff spoke highly of the working culture. Senior management were visible, approachable and engaged with staff.
- Some staff felt senior management styles could be overpowering at times, although this was not reflected by the majority of staff we spoke with.
- We did not see evidence of a strong emphasis on promoting the safety and wellbeing of staff, and a number of incidents reported showed staff were sometimes working through breaks.

We saw several areas of outstanding practice including:

- The treatment centre had a policy that allowed any member of staff at any time to call a multidisciplinary team meeting if they had any concerns about any aspect of a patient's care.
- The safeguarding policies and procedures were well established and well understood by staff who gave us many examples of where the safeguarding process had been followed to help protect vulnerable adults receiving care in the hospital.
- Pharmacy staff were involved in projects to help simplify information given to patients about their medicines. This included easy-read medicines sheets and a colour-coded system for the administration of eye drops post-surgery.
- The senior managers were very visible and welcomed engagement with staff and patients in both a positive and constructive manner, and frequently served as first point of contact in situations where patients were unhappy with services.
- A patient forum was set up to engage with patients and be involved with a lot of internal processes and meetings. In particular, patient forum members attended and participated in the monthly clinical governance meetings.
- Staff were very quick to offer patients apologies and the opportunity for a conversation following an incident where something had not gone as well as it should. Learning from these conversations and subsequent investigations was shared throughout the Care UK organisation.

Summary of findings

- The hospital welcomed and was responsive to patient feedback, including feedback about patient toilets and adding specialty food items to the canteen menu.
- The physiotherapy enhanced recovery programme allowed detailed monitoring of the effectiveness of patient treatment at six weeks, with the option to refer back to the consultant if any concerns about the patient's progress arose.
- Free telephone calls were available for all patients to landlines and mobile phones to enable them to remain in contact with their family during their stay.

There were some areas where the provider needs to make improvements.

The provider **should**:

- Ensure effective communication takes place between consultants at all times and implement a clear system to flag urgent referrals.
- Consider having a contingency plan in case the diagnostic imaging computed radiography reader breaks down.
- Ensure mandatory training is completed in accordance with Care UK targets.
- Maintain records of regular tap flushing.
- Ensure effective stock management is in place and that out of date items are removed from circulation.
- Implement a system to ensure diagnostic imaging staff follow up urgent referrals with GPs in all cases.
- Consider alternative parking arrangements for patients and relatives.
- Ensure the pharmacy recording, tracking and monitoring systems are fit for purpose.
- Consider enhanced training for prescribers to make sure all referral information is taken into consideration at the time of prescribing 'to take out' medication.
- Ensure the number of patients booked into a clinic is appropriate to the length and staffing of that clinic.
- Ensure staff are allowed time to take allocated meal breaks.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	The surgery services at Emersons Green NHS Treatment Centre were rated as good overall, with leadership rated as outstanding. We found: • Staff were open and honest when things didn't go as planned and were encouraged to report incidents by the senior management team. • All staff knew how to use the incident reporting system and we saw evidence of changes to practice that had been made as a result. • We saw evidence of learning to support improvement which was communicated to all departments and not those just directly affected. • An open culture was encouraged and staff understood the duty of candour and the principals of openness, honesty, integrity and providing an apology. • The ward, theatre and endoscopy departments were all visibly clean, organised and well maintained. Staff followed infection, prevention and control policies. • We observed good use of the WHO five steps to safer surgery checklist and minutes of theatre brief and debrief checklists. • There were sufficient numbers of staff to safely meet the needs of patients and medicines were managed safely. • Care and treatment was planned in line with evidence-based guidance, standards and legislation. • Consent to treatment was sought and documented in line with legislation. • Staff had the skills required, and were qualified, to carry out their roles effectively in line with best practice and were also provided with specialist training to cope with any eventuality on the ward. • The multidisciplinary team shared responsibility for delivering care and treatment and worked together to co-ordinate this. • Staff communicated and responded compassionately with patients and explained things in a way patients could understand.

Summary of findings

- Patients were involved and encouraged to be partners in their care and decision making.
- Staff gave patients the time to ask questions about their care and treatment and also involved other family members throughout the process to ensure the patient was supported.
- Staff provided patient-centred care which was reassuring, caring, compassionate and supportive.
- Staff ensured privacy and dignity of the patient was maintained and independence was encouraged during their stay at the treatment centre.
- All feedback we received about the staff was very positive.
- The needs of different people were accounted for when planning and delivering services.
- Staff were responsive to individual patients' needs.
- Staff demonstrated how they supported patients with learning difficulties, their families and carers, to reduce anxiety before the day of the procedure.
- Staff also demonstrated how they made allowances for patients to ensure care and treatment delivery met their needs.
- Complaints and concerns were always taken seriously and responded to in a timely way.
- The treatment centre took a proactive approach to make changes on the basis of patient feedback.
- The treatment centre had a challenging, yet achievable, vision and strategy that staff were aware of and involved with achieving.
- Work was actively ongoing with external stakeholders to help deliver the vision and strategy, and to provide the best service for patients.
- The senior management team were an enthusiastic, committed team delivering safe, patient centred care. Staff and patient engagement was embedded in the culture at the treatment centre.
- There were strong governance processes at all levels in the treatment centre, with a monthly quality assurance meeting attended by all clinical and non-clinical staff, as well as the patient forum.

Summary of findings

- There was a strong focus on improving quality of care and patient experience.
- The vast majority of staff spoke highly of the working culture. Senior management were visible, approachable and engaged with staff.

However:

- There were occasions when staff felt overwhelmed by the senior management team and felt their work and decision-making was not trusted.

Outpatients and diagnostic imaging

Good

The outpatient and diagnostic services at Emersons Green NHS Treatment Centre were rated as good overall, with caring rated as outstanding. We found:

- There were good systems in place for incident reporting and learning when things did not go as planned.
- Systems were in place for the safe administration of medicines and for the prevention of infection.
- Staff were knowledgeable about safeguarding and their responsibilities to vulnerable adults.
- Staff were knowledgeable about their duty of candour towards patients.
- Staff were very competent in the roles they were being asked to perform.
- There was good multidisciplinary working within the hospital.
- Staff captured data about patient outcomes, and used it to make changes to the way they worked.
- Staff communicated in a professional but friendly manner with patients and their families.
- Comments from patients and relatives were extremely positive about the staff and how they provided their care and treatment.
- Patients were involved in their care and treatment and their needs were always put first. The hospital put patients at the core of the services they delivered.
- The departments provided a good service to make sure people were not waiting long periods of time for either outpatients or diagnostic services.
- We saw the hospital was achieving all of its referral to treatment standards across all specialties.

Summary of findings

- We saw evidence that complaints were discussed at departmental and higher level meetings and changes were made where necessary to help improve services and prevent further complaints.
- The hospital welcomed all feedback from patients, and made changes to services if necessary.
- Staff were supported at all levels, from their immediate manager through to the hospital executive team, including the hospital director.
- Good governance systems were in place across outpatients and diagnostics.
- The majority of staff we spoke with felt the culture was open and that staff strived to make sure the experience for patients was outstanding in line with the hospital's values and vision.
- The hospital engaged with the patient forum and used them to help develop services.

However:

- The hospital target of 90% compliance with mandatory training in January 2016 had not been met in outpatients or physiotherapy.
- Some staff described the style of management of some senior managers as overpowering, although we did not find this view shared by the majority of staff.
- Diagnostic imaging staff did not always follow up urgent results with GPs.
- The electronic patient record system was prone to slow down, and the hospital had identified a risk should it stop working completely.

Summary of findings

Contents

Good

Emersons Green NHS Treatment Centre

Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Emersons Green NHS Treatment Centre

Emersons Green NHS Treatment Centre is an independent hospital situated in Bristol. It opened in 2009 and provides services to people living in Bristol, North Somerset, South Gloucestershire, Wiltshire, Gloucestershire, Bath, North East Somerset, Swindon and South Wales.

Independent NHS treatment centres are private-sector owned treatment centres contracted to treat NHS patients free at the point of use. Emersons Green NHS Treatment Centre is run by Care UK, the largest independent provider of NHS services in England.

The treatment centre provides routine surgery, outpatient and diagnostic imaging services in a modern purpose-built hospital. Specialities for which treatment is available include: ophthalmology, oral surgery, ear, nose and throat, general surgery, orthopaedics, gynaecology, urology and endoscopy.

Admission to the treatment centre for surgery follows strict referral criteria for people aged 16 years and over who required routine surgery.

There is an outpatient department in the treatment centre for routine pre- and post-operative appointments.

The treatment centre has an inpatient ward with 33 bed spaces. There are four operating theatres, one minor procedure room and two anaesthetic induction rooms, operating Monday to Saturday.

We carried out a comprehensive announced inspection of Emersons Green NHS Treatment Centre on 30 and 31 March 2016, and an unannounced inspection on11 April 2016.

We inspected the following two core services:

- surgery
- outpatients and diagnostic imaging.

Our inspection team

Our inspection team was led by:

Inspection manager: Daniel Thorogood, Care Quality Commission.

The team included CQC inspectors, one expert by experience and three specialist advisers , including a consultant surgeon, a theatre nurse and an outpatients nurse.

How we carried out this inspection

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

- **Is it safe?**
- **Is it effective?**
- **Is it caring?**
- **Is it responsive to people's needs?**
- **Is it well led?**

Before visiting, we reviewed a range of information we held about the hospital and requested further information from the provider.

We visited the treatment centre to undertake an announced inspection on 30 and 31 March 2016 and undertook an unannounced inspection on 11 April 2016.

As part of the inspection process we spoke with members of the executive management team and individual staff of all grades. We met with staff working within the surgical, endoscopy and outpatient areas, as well as administrative staff.

Summary of this inspection

We spoke with patients and their relatives and looked at comments made by patients when completing the hospital satisfaction survey. We also reviewed complaints that had been raised with the hospital.

We inspected all areas of the treatment centre over a two-day period, looking at outpatients and diagnostics, and surgical care.

We spent time observing care in the operating theatres, outpatients department and the inpatient ward. We reviewed policies, procedures, training and monitoring records, as well as patients' records where necessary.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

1. We currently do not rate effectiveness in outpatients and diagnostic imaging.

Good

Surgery

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

Information about the service

Emersons Green NHS Treatment Centre provided a range of NHS surgical services for adults and young people covering the population of Bristol, Bath, North and North East Somerset, South Gloucestershire and populations further afield including Gloucestershire, Wiltshire and South Wales.

Both day-case and inpatient surgery specialities were offered at Emersons Green, including ear, nose and throat procedures, endoscopy, general surgery, gynaecology, minor orthopaedic surgery, joint replacements, diagnostic imaging, pain management, ophthalmology, urology and dental surgery.

Emersons Green had a 33 bed inpatient ward, four operating theatres, a procedure room, day case treatment room, a post-anaesthetic extended recovery unit, sterile services department and an endoscopy suite.

Between October 2014 and September 2015, 15,501 operations were undertaken at Emerson Green NHS Treatment centre. The most common procedures were cataract surgery, dental extraction, colonoscopy, gastroscopy, hip replacements and knee replacements.

On this inspection, we visited the surgery service on 30 and 31 March 2016. We visited the surgery ward, theatres, post-anaesthetic extended recovery unit, sterile services department and the endoscopy suite. We spoke with staff including nurses, healthcare assistants, theatre managers, operating department practitioners and staff from endoscopy and the post-anaesthetic extended recovery unit. We also met the management team including the hospital director, medical director, head of clinical services, ward matron, ward sister, consultants and registered medical officers. We also talked with pharmacy staff and a physiotherapist. We met with eight patients and 31 members of staff. We observed care and looked at records and data.

Good

Surgery

Summary of findings

Surgery services at Emersons Green NHS Treatment Centre were judged to be good overall, with leadership rated as outstanding. We found:

- Staff were open and honest when things didn't go as planned and were encouraged to report incidents by the senior management team. All staff knew how to use the incident reporting system and we saw evidence of changes to practice that had been made as a result. We saw evidence of learning to support improvement which was communicated to all departments and not those just directly affected. An open culture was encouraged and staff understood and implemented the duty of candour and the principals of openness, honesty, integrity and providing an apology.
- The ward, theatre and endoscopy departments were all visibly clean, organised and well maintained. Staff followed infection, prevention and control policies. We observed good use of the WHO five steps to safer surgery checklist and minutes of theatre brief and debrief checklists. There were sufficient numbers of staff to safely meet the needs of patients and medicines were managed safely.
- Care and treatment was planned in line with evidence based guidance, standards and legislation. Evidence-based risk assessments for venous thromboembolism to ensure patient safety and evidence based information was provided to patients on discharge. Consent to treatment was sought and documented in line with legislation. Staff had the skills and were qualified to carry out their roles effectively in line with best practice and are also provided with specialist training to cope with any eventuality on the ward. The multidisciplinary team shared responsibility for delivering care and treatment and worked together to co-ordinate this.
- Staff communicated and responded compassionately with patients and explained things in a way patients could understand. Patients were involved and encouraged to be partners in their care and decision making. Staff gave patients the time to ask questions about their care and treatment and also involved other family members throughout the process to ensure the patient was supported. Staff provided patient-centred care which was reassuring, caring, compassionate and supportive. Staff ensured privacy and dignity of the patient was maintained and independence was encouraged during their stay at the treatment centre. All feedback we received about the staff was very positive.
- The needs of different people were accounted for when planning and delivering services. Staff were responsive to individual patient's needs. Staff demonstrated how they supported patients with learning difficulties, their families and carers, to reduce anxiety before the day of the procedure. Staff also demonstrated how they made allowances for patients to ensure care and treatment delivery met their needs. Complaints and concerns are always taken seriously and responded to in a timely way. The treatment centre took a proactive approach to make changes on the basis of patient feedback.
- There were good governance structures in place which demonstrated effective processes around learning, change and improvement. There were effective governance frameworks in place taking information from senior management level to clinical staff and quality received sufficient coverage in board meetings and other relevant meetings below board level. The treatment centre was transparent, collaborative and open with all staff and stakeholders. Leaders encourage supportive relationships amongst staff and made them feel respected and valued. Senior management took a pro-active approach to involve the patient forum representatives in their governance meetings and acted upon feedback provided. Senior managers were visible and approachable and staff told us they felt comfortable to raise concerns if necessary. There was a strong focus on learning and improvement at all levels of the organisation and staff were encouraged to be involved in quality and improvement working groups at the treatment centre.

However,

Good

Surgery

- There were times when staff felt overwhelmed by the senior management team and felt their work and decision making was not trusted.

Are surgery services safe?

Good

Overall, we have judged the safety of the surgical service as good because:

- Staff understood their responsibilities to report incidents and how to report them. Staff were made aware of learning points and action plans from reported incidents.
- Staff were aware of the principles of the duty of candour and were open, transparent and apologetic to patients when things went wrong.
- The ward and theatres were visibly clean and staff followed infection prevention and control protocol.
- We saw evidence that most equipment was maintained and checked regularly.
- Staff were all aware of their roles and responsibilities in reporting a safeguarding concern and knew how to go about this process. They were also aware of where they could get further information to help them with this process.
- There was a full complement of staff on the ward, including a good skill mix, to keep people safe from avoidable harm. There was access to well-inducted and competent bank and agency staff to fill any gaps.
- There was good use of the surgical safety checklist in theatres and staff were aware of their roles and responsibilities.
- Incident reporting data had identified a trend in poor reporting of patient allergies prior to October 2015. However, actions had been put in place and allergy reporting had improved.

However:

- We found out of date equipment stored on the ward.

Incidents

- Staff were encouraged to raise concerns and incidents. We observed 'speak up for a healthy service' posters on

the walls in the ward and staff room. The posters provided contact details for staff to raise concerns. Staff told us they felt comfortable raising concerns with management.

- Staff were aware of their responsibilities to raise concerns and understood the process of how to report incidents. Staff had access to computers to report incidents on the electronic reporting system. All staff we talked with said the process was straightforward. There were 320 clinical incidents and near-misses reported in the period October 2014 to December 2015. Incident reporting was embedded in the culture at the treatment centre.
- Staff received feedback about incidents logged on the incident and reporting system if requested. Staff on the ward told us learning from incidents was sent by email and discussed during staff briefings which took place during shift handovers when appropriate. Information was also recorded in the safety briefing folder which was read out to staff at the start of each shift.
- There had been no never events reported in the previous 12 months. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- There was a system in place for the management of serious incidents and all relevant staff were involved in reviews and investigations. This was to enable learning and actions to be implemented to improve safety and reduce the likelihood of the incident happening again. There had been four serious incidents reported between the reporting period October 2014 to September 2015, of which one related to surgery. We were told by the governance lead that when a serious incident occurred, a meeting was called with the complete multidisciplinary team involved in the incident. If required, an external investigation was launched. This happened as a result of a controlled drugs incident in June 2015. Relevant managers had completed root cause analysis training to ensure thorough investigations were completed and documented. Once completed, the final root cause analysis was sent to the Care UK head office and to the local clinical commissioning group serious incident panel for review.
- Staff were made aware of changes to policy and practice following an incident in order to improve safety. We were told about one incident where the dosage of a medicine had been adjusted and not communicated to other staff. The findings of the investigation were fed back at the governance meeting and actions to prevent a reoccurrence were communicated to all staff. Information was also cascaded to staff during departmental meetings, speciality team meetings and monthly quality assurance meetings.
- The treatment centre had safety goals in place to improve patients' safety and service quality for 2016. We saw examples of the safety goal to reduce the number of inpatient falls. We observed action plans, review dates and recent progress reports with set goals for completion.
- Lessons were shared to improve safety beyond the affected team. For example, we saw evidence of learning from a controlled drugs incident being shared with all staff across the treatment centre at the monthly quality assurance meeting, at departmental meetings and in emails sent to staff.
- Staff were familiar with their responsibilities under the Duty of Candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the provider to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Staff throughout the department demonstrated an understanding of this and the actions that needed to be taken when patient treatment and care had gone wrong or not been satisfactory. We saw evidence that the duty of candour was being applied where necessary, with incident reports having a dedicated section for recording duty of candour actions.
- Surgical mortality and morbidity meetings were held on a monthly basis and learning and action points were fed into the service to make improvements to quality and safety. There had been no cases of unexpected deaths at the treatment centre between October 2014 and

September 2015. We saw copies of recent minutes from mortality and morbidity meetings from December 2015 and January 2016 and evidence of action plans to improve quality and safety.

- There were five incidents of venous thromboembolism (VTE) in the 12 month period between October 2014 and September 2015 (0.10% of patients); one in February, one in March, one in July, one in August and one in September 2015. In the six months October 2015 to March 2016 there had been seven incidents of VTE (0.27% of patients); one in October and December 2015, three in January and two in March 2016. We saw two examples of root cause analysis investigations carried out to identify the causes of two of the VTE incidents and saw learning had been put in place to prevent recurrence in these circumstances. Of the remaining VTE incidents there did not appear to be any common themes, with appropriate prophylaxis (treatment given to prevent VTEs) being administered in all cases.

Safety thermometer

- The treatment centre participated in the monitoring of patient care in line with the NHS Safety Thermometer. The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and 'harm-free' care on one day a month. This covers areas including falls, pressure damage, infection control, venous thromboembolism (VTE) and catheter associated urinary tract infections. The treatment centre had provided 100% harm free care during the reporting period March 2015 to March 2016. This information was not displayed for the public to see.

Cleanliness, infection control and hygiene

- The operating theatres, ward, recovery area and endoscopy department were visibly clean, organised and well maintained.
- There were reliable systems in place to prevent people from healthcare associated infection. Staff in all departments were compliant with infection prevention and control principles. Hand washing sinks and gels and personal protective equipment were readily available. We observed staff washing their hands and using personal protective equipment when appropriate. We observed staff following infection control principles of no jewellery and being bare below the elbows. Monthly hand hygiene audits were completed and in November 2015 and January 2016 these showed 100% compliance.
- Daily observational checks of the environment in theatre and recovery were carried out. The theatre manager and senior nurse carried out a daily walk around the department to check for cleanliness. They also ensured that infection control policies were being followed. We were told that any issues were dealt with immediately.
- Staff were kept informed about local infection prevention and control policies and principles. An infection control notice board was located in the staff room on the ward providing information about prevention of norovirus, infection control rate, a flow diagram detailing management of blood-borne viruses and post-exposure prophylaxis (a preventative medical treatment started immediately after exposure to a disease-causing virus, in order to prevent infection).
- The treatment centre had clear cleaning procedures in the anaesthetic rooms, theatre and endoscopy. Cleaning duties were carried out by a member of the theatre team. We observed completed and signed daily cleaning logs for March 2016 in all departments.
- Green 'I am clean stickers' were visible on large pieces of equipment to identify it had been cleaned and was ready for use.
- The treatment centre reported there had been no incidents of methicillin resistant Staphylococcus aureus (MRSA), Clostridium difficile (C-diff) or methicillin-susceptible Staphylococcus aureus (MSSA) during the reporting period October 2014 to September 2015.
- There were safety systems in place to monitor practice and processes to ensure compliance with infection prevention and control principles relating to the environment and equipment. There was an active audit schedule in theatres for the reporting period October 2015 to September 2016. An infection control link nurse was based in theatres who carried out the audits. In the January 2016 audit of the environment and utility rooms, 96% compliance was recorded. In February 2016 the store room, domestic store and water cooler audit scored 96%. Audits were reported against a target of

90%. If an audit score fell below 90% an action plan was written and actioned. We observed an action plan following an audit of the general environment in theatres in March 2016. From this, hand hygiene posters had been put up around theatres and damaged ceiling tiles had been repaired. The department was still waiting for cracks in the flooring to be fixed at the time of our inspection.

Environment and equipment

- Electrical equipment was maintained in order to keep people safe. Equipment was labelled with appropriate stickers to indicate recent electrical testing in the endoscopy department and on the ward. Maintenance and service logs for all equipment in theatre were in date. An electronic maintenance log was used to monitor servicing and alerts were sent to the relevant manager by the administrator when equipment was due a service. We were told that in the event of equipment failure the department had spare equipment that could be used.
- Daily, weekly and quarterly checks of equipment were carried out in the central sterile services unit to ensure safety. The department had two recent inspections from the British Standards Institution (BSI). The British Standards Institution is an organisation that provides codes of practice around quality standards. The British Standards Institution has an accreditation against internationally recognised standards providing highest levels of quality and service and imposes high expectations and standards to meet specific proposed codes of practice. The central sterile services unit scored 100% during these inspections. During a further unannounced inspection the department again performed well. The lack of pressure data recording was the only negative point raised by the BSI. During our visit to the central sterile services unit one of the machines was displaying an error message. We observed a member of staff restart the machine in line with set protocols to fix the problem.
- There were systems to monitor the environment and equipment daily. A log book was provided for staff in recovery and on the ward to sign to identify all checks had been completed. We observed completed daily monitoring of the environment and equipment for March 2016 in both areas.
- Sharps bins around theatre and recovery were clearly labelled, dated and not overfilled.
- Control of substances hazardous to health (COSHH) assessments had been carried out to ensure the safety of staff and patients. In endoscopy, we observed that iodine alcoholic preparation, chlorine, germicidal and disinfectant wipes had all undergone updated assessments in February 2016. However, in theatre we found three COSHH risk assessments where review dates were overdue.
- During our visit we found evidence of out of date equipment on the ward. Out of date equipment included a catheter spigot (sterile tubing closures for catheters), vacutainer blood bottles (bottles that store blood), a 1ml syringe and a vacutainer blood transfer device (a device that reduces the risk of blood transfer injuries). The deputy ward manager was made aware of this immediately and disposed of the out of date equipment. We were told that catheter spigots were rarely used on the ward. Cartridges for processing results for a variety of clinical tests were also found to be out of date. When this was raised with staff we were told this equipment should be stored in the fridge. We were told the likely cause was a staff member had gone to dispose of these due to them being out of date but had been called away before being able to carry out this procedure.
- There was safe provision of resuscitation equipment in all departments. Resuscitation trolleys (which included defibrillators and other emergency equipment and medicines) were tamper-evident, located to be immediately accessible and checked daily. We reviewed the log book for March 2016 and found all checks had been completed. All equipment on the trolley was in date. There was a designated resuscitation officer that carried out monthly audits of the resuscitation equipment.
- Anaesthetic machines were checked and maintained daily in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) 'Checking anaesthetic equipment' 2012 guidelines. A member of theatre staff carried out daily checks and audits were randomly carried out by a senior member of the anaesthetic team and we saw evidence that these were being completed.

Medicines

- Medicines were managed and stored in a way that kept people safe from avoidable harm.
- Systems and processes for the safe management of controlled drugs on the ward were in place and communicated to staff. Controlled drugs checks were carried out at the beginning and end of the working day in theatres by two members of staff and signed off in the register. We saw these were being completed. This practice was introduced and communicated to staff after a controlled drugs incident in June 2015. We also saw random unannounced audits for controlled drugs were being carried out by the pharmacist.
- Medication on the ward and in theatre was monitored by the pharmacy department. The pharmacy dispenser visited daily to observe and replenish stock.
  Each medicine was checked and a list of medications required to replenish stock was manually recorded into a diary. The dispenser would then bring new stock back to the area required and arrange to ensure the stock with the most recent expiry date was used first. All medicines could be traced using the manual recording system. Controlled drugs were replenished three times a week. Orders were placed with the pharmacy department, then counted, checked and signed in by a member of staff and the pharmacist.
- Medication was managed safely in theatres. There were good prescribing protocols for medication in theatres. We observed printed medicine labels which reduced the risk of staff getting the name or dose of medication wrong.
- Patient medicines were checked during daily ward rounds between the pharmacist and consultant. Medication brought in by the patient was also checked. We were given an example of an error found in the patient's own medication. The pharmacist arranged for this medication to be replaced.
- Fridge temperatures were checked daily and recorded in recovery and on the ward. We saw completed log books for fridge temperature checks in recovery, the ward and theatres for March 2016.
- There were good procedures in place for medicine reconciliation at the treatment centre. Medicine reconciliation is the process of creating the most accurate list of all medications a patient is taking, including name, dosage, frequency, and route. The goal was to ensure the patient was protected against avoidable harm from medication errors, omissions or medicine interactions. A monthly audit of 10 patients was carried out as recommended by NICE guidelines. The pharmacist told us they were looking at expanding this number to give a better understanding of the treatment centre's performance with medicines reconciliation.
- Poor documentation of allergies had been a recurrent theme on the electronic incident reporting log. Data was recorded weekly around missed or incorrect allergies. An action plan to improve recording had been put in place. All staff attended mandatory allergy training and issues were taken to monthly mortality and morbidity meetings. Emails were circulated to staff identifying issues, current best-practice evidence using National Institute for Health and Care Excellence (NICE) guidelines and examples of good practice around allergy recording. The situation had now improved and only two incidents regarding allergy recording had been reported between October 2015 and January 2016. We also saw evidence of complete allergy recording on six randomly observed prescription charts.
- The pharmacy department collected data about medication recording and compliance on a weekly basis. We observed data collection sheets which were fed back at mortality and morbidity meetings and governance meetings. This identified areas of weakness and prompted action plans and feedback to staff to improve safety and practice around medication recording.
- An antimicrobial stewardship was being set up at the treatment centre. Antimicrobial stewardship is a set of coordinated interventions designed to improve and measure the appropriate use of antibiotics by promoting the selection of optimal medicine regime, dose, and duration of therapy and route of administration. Current support for clinicians had been implemented through access to current guidelines on the staff intranet and microbiology support for clinicians from North Bristol Trust. Terms of reference, local groups and treatment guidelines were currently waiting to be confirmed and approved.

Records

- Individual care records were written and managed in a way that protected people from avoidable harm. Pre-operation assessment documentation was stored electronically on the patient record system and was available throughout the patient's journey.
- The intraoperative care plan was recorded using the electronic patient record. Once the patient had left theatre and the notes were completed the scrub nurse closed down the record. The surgeon's notes, including post-operative instructions, were recorded on the electronic patient record, handed over verbally and provided on the written handover sheet. This information was then passed to the receiving nurse in the recovery area to ensure a good understanding of what was required after the operation for safe care and treatment.
- All case notes were typed onto the electronic patient record system during the patient journey. Paper notes were retained for back up in case the electronic system failed and to gain written signatures for consent.
- We examined six sets of patient records on the ward. Notes were clear, accurate, up-to-date, signed and stored securely. We also reviewed six prescription cards which clearly identified allergies, medicine omissions or delays and reasons, and prescribed antibiotics. All cards were legible, signed and dated.
- Documentation in theatre was clear and complete. We observed good documentation in theatres of completed care plans, national joint registry forms and consent forms.
- A documentation audit was completed quarterly. In February 2016 the audit demonstrated compliance between 94% and 100% against a target of 95%. The issue identified was with consistency of surgeons completing records, which only had 75% compliance. The parts that had remained incomplete were the provision of contact details for the consultant and documentation that the patient had been offered further information and whether or not this or had been accepted or declined.
- Endoscopy audited patient documentation and consent forms on a monthly basis. The joint advisory group (JAG) (a group ensuring the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practised) audit tools were completed using a selection of 20 patient case notes. The lead endoscopy nurse reviewed the results and produced action plans if areas of non-compliance were identified. We were given an example of poor completion of patient contact details. An email was circulated around the department to highlight this issue to all staff. This issue had now been resolved.
- Staff were given training to use the electronic patient record system. This was carried out when a new member of staff member started at the treatment centre. The ward had a trainer that would come and teach staff on a one to one basis. We were told by staff that it took time to get used to using the system.

Safeguarding

- There were systems and processes in place that were essential to protect people from abuse. Staff were aware of their responsibilities about safeguarding and understood the processes for reporting safeguarding concerns. There was a safeguarding file located on the ward at reception containing the policy and information about who to contact if a concern needed to be raised. Staff also told us they had access to the safeguarding policy on the staff intranet. We were given an example of a recent safeguarding issue raised at the treatment centre. All pathways and procedures were followed according to Care UK policies.
- Staff were trained up to and including level two safeguarding training for both adults and children. This was delivered in a face to face session. For the month ending January 2016, there was a 92% compliance rate with safeguarding adult training at the treatment centre and a 79% compliance with children's safeguarding training. The safeguarding leads had been trained to level three safeguarding standards for both adults and children.
- The treatment centre had designated safeguarding leads for adults and children. Staff knew who the leads were and told us they would go to them to for support or to discuss any safeguarding concerns.

Mandatory training

- Staff followed a mandatory training programme which was a mixture of classroom and online learning. We saw records of the mandatory training compliance report for the end of January 2016. The treatment centre had a target of 90% completion for mandatory training. Staff

compliance for mandatory training was 100% for COSHH, 98% for intermediate life support and adult life support, 90% for infection control, 89% for patient consent, mental capacity act and deprivation of liberty safeguards, and 86% for medicines management.

Assessing and responding to patient risk

- Risk assessments and risk management plans were used to keep patients safe and were in line with national guidance. The national early warning score (NEWS) was used to identify deteriorating patients. The NEWS system uses numerical scoring of patient observations to highlight risks. NEWS scores were accurately recorded in patients' notes and used to manage risks to patients.
- The endoscopy department used basic observations to monitor patient safety and wellbeing during procedures. Oxygen saturations, blood pressure and pulse oximetry were checked every 10 minutes. Procedures were stopped if the observations indicated the patient was in distress. Staff told us they had not experienced a deteriorating patient but if required they would put out a call for urgent medical assistance in accordance with the treatment centre's policy.
- Staff were aware of policies, procedures and pathways used to respond to a deteriorating patient. A clear protocol was in place to transfer a deteriorating patient to an NHS hospital by requesting a 999 emergency ambulance. The process required an initial discussion between the surgeon, anaesthetist and resident medical officer, followed by a verbal handover from the consultant to the receiving NHS hospital's consultant. A medical escort (usually the anaesthetist) would be required to travel with the patient in the ambulance, and a handover document and relevant medical notes would also be transferred.
- There had been 13 cases of unplanned patient transfer between October 2014 and September 2015. These had been spread out over the course of the reporting period, although there were three in April 2015. There were no transfers to the local NHS hospital in December 2014, June or July 2015. We reviewed details of the transfers and there were no obvious trends. Each case had been discussed and reviewed at the clinical governance meeting, and if appropriate at the mortality and morbidity meeting.
- The service demonstrated good compliance with the World Health Organisation's (WHO) five steps to safer surgery checklist (an initiative designed to strengthen the commitment of clinical staff to address safety issues within the surgical setting). A copy of the WHO checklist was stored in the patient's file. The WHO checklist and its importance was understood by all staff and was embedded into the culture at the treatment centre. Monthly audits of the WHO checklist were carried out by the theatre manager. The results of the audit for March 2016 were 100%.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so people received safe care and treatment in line with the National Institute for Health and Care Excellence safe staffing guidelines. The ward was meeting its full nursing establishment and there were sufficient senior members of staff to support junior members with providing safe care and treatment. There was a good skill mix of staff including one ward manager, one deputy ward manager, four senior nurses, eight whole time equivalent (WTE) band five nurses, four part-time nurses, one assistant practitioner, four full-time health care assistants (HCA) and one part-time HCA.
- Theatre staffing was based on the Association for Perioperative Practice (AfPP) guidelines. There were 44 WTE staff working in theatre and recovery. There were two scrub nurse vacancies and one vacancy for a senior nurse. There was also a 0.8 WTE post for a nurse in recovery.
- A 'red flag audit' was completed weekly to capture information about nursing staffing levels. This was discussed monthly with the senior management team to identify actions to be taken to improve staffing and skill mix. Information about the number of nursing staff on duty was visible to patients in the reception area. The information also explained to patients the numbers of nurses needed to ensure safety.
- The endoscopy department identified nursing staff requirements and skill mix using recommendations by the joint advisory group (JAG). JAG ensured the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practised. There were eight WTE nurses working in the endoscopy

department. During a procedure, two registered nurses and one HCA were required to be present in the treatment room. This met the safe staffing requirement recommended by JAG.

- Bank and agency staff were used to cover staff sickness or shortages. When agency staff were used, they were booked in blocks to ensure continuity for both staff and patients. Training and induction programmes were in place for all agency and bank staff and we saw evidence of these being completed and documented.
- Handovers were carried out twice a day at shift change. Each patient was discussed in turn and then the nurse in charge would allocate nurses to patients. A safety briefing was also carried out on a daily, weekly and monthly basis focusing on issues such as signing off medication and administration reminders.
- Nurses on the ward were required to go and collect patients from the recovery area. This took the nurses away from patient care for short periods of time throughout the day.

Surgical staffing

- There were adequate numbers of consultants and anaesthetists to meet the needs of patients. The service was consultant-led. Consultants were responsible for their patients' care 24 hours a day, seven days a week. Consultants were available during working hours and there were on call rotas in place for the different specialities outside of working hours. It was the responsibility of the administration team to organise the rota and the senior management team to arrange the most appropriate cover. We were told the on call consultants could be contacted at any time and staff told us they felt very supported. We were told by the senior management team that there was a 40 minute timeframe for a consultant or anaesthetist working on call to come in and attend to a patient.
- One 'floating' anaesthetist was based in the outpatient department during working hours to ensure safe care and treatment of patients when all other consultants and anaesthetists were busy. The floating anaesthetist would attend any emergencies as required and attend to any deteriorating patients. There was an anaesthetist on call overnight who could be contacted for support or advice and would come in if required. There were three further bank anaesthetists who could be called in at short notice if required.
- There was 24 hour, seven day a week cover by the registered medical officers (RMO's) on the ward. They worked 12 hour shifts and would escalate concerns to the consultant on call out of hours if required. The RMO's completed routine tasks for the consultants, including blood tests and prescribing medicines, and supported consultants on ward.
- Handovers were carried out between RMO's twice a day during shift changes. These were paper-based and were updated during the shift of the RMO on duty. We observed a handover sheet during the inspection. This was well written and provided detailed information about the patients and their treatment.

Major incident awareness and training

- There were arrangements in place to respond to emergencies and major incidents. Staff told us that if an emergency situation arose they would use the emergency call bell to call for assistance. There was also a floating anaesthetist available based in the outpatient department who would respond to emergencies.
- Risks were identified and plans put in place to mitigate against them. For example, the electronic patient record system was recorded on the risk register. The system had, on occasions, become unreliable because it would run too slowly to be used. As a result, paper-based records were also maintained to ensure safe continuity of care in the event the system failed to respond.

Are surgery services effective?

Good

We have judged the effectiveness of the surgery service as good because:

- An evidence-based enhanced recovery programme was used for patients undergoing hip or knee replacements.
- Risk-based venous thromboembolism assessments were carried out to ensure patient safety.

- The treatment centre scored better than the England average in its Patient Reported Outcome Measures for hip replacement and varicose vein surgery for the reporting period October 2014 to September 2015.
- Staff were qualified and had the skills to carry out their roles effectively with a variety of internal training provided by speciality consultants.
- There was evidence of good multidisciplinary team working across all departments to ensure effective patient care.
- Discharge planning was started early at the pre-operation stage, including follow-up appointments and organisation of continuing care packages.

Evidence-based care and treatment

- Evidence-based guidelines and best practice were used to develop how services, care and treatment were delivered. Care was provided in line with guidance from the National Institute for Health and Care Excellence (NICE). For example, NICE NG45 was followed regarding pre-operative tests. The pharmacist also attended ward rounds to monitor patients' medication and pain relief to optimise patient outcomes. The National early warning score, a national recognised tool to identify a deteriorating patient, was routinely used for all patients. The malnutrition universal screening tool (a tool used to establish nutritional risk) and waterlow score (a scale to identify patients that are at risk of a pressure sore) were used to ensure evidence-based care planning and treatment specifically for the individual.
- Effective use of a venous thromboembolism (VTE) risk assessment tool was demonstrated in theatre. The protocols followed were standardised and followed NICE pathways for VTE. Patients were screened for the risk of developing a VTE before having surgery and given preventative treatment if required. The VTE screening audits showed the treatment centre was screening over 99% of patients between October 2014 and September 2015. This was better than the target of 95%. However, there had been seven incidents of hospital acquired VTE between October 2014 and September 2015.
- An enhanced recovery programme was being used for patients who had a total hip or knee replacement surgery. Enhanced recovery was an evidence-based approach that aimed to improve patient outcomes and speed up recovery after surgery. It aimed to make patients active participants in the recovery process.
- All patients who underwent joint replacement surgery consented to have their prosthesis registered on the National Joint Registry. This was done to contribute to the ongoing monitoring of the NHS on the performance of joint replacement implants, the effectiveness of different types and to improve the quality of clinical practice.
- Patients were provided clear evidence-based information about post-operative care on discharge. Patient information leaflets in the endoscopy department were provided in line with the British Society of Gastroenterology guidelines. We saw these information leaflets and observed them being provided to patients on discharge detailing clear post-operative care information.
- The endoscopy department received joint advisory group (JAG) accreditation in November 2015. The joint advisory group sets standards around best practice and quality assures endoscopy units to ensure endoscopy departments have the skills and resources to provide high quality patient-centred care. The accreditation demonstrated the department had the competence to deliver against specifically defined, recommended standards. The department had submitted data to renew their accreditation in May 2016.
- Staff had access to policies and standard operating procedures (SOP's). These were located on the staff intranet. There were also paper copies stored in files containing the policies and SOPs for staff to access on the ward and in theatre.

Pain relief

- Pain was regularly reviewed and pain relief administered to ensure patients were comfortable. Ward rounds dedicated to reviewing patients' pain took place on a daily basis and were attended by the consultant, pharmacist and nurse. Patients' pain was assessed and recorded both prior to, and after, surgery. A numerical rating scale of zero to 10 was used, with zero being no pain and 10 being unbearable pain. Pain relief was prescribed and adjusted accordingly and recorded in patients' notes. The notes were also reviewed to ensure

the patient was able to tolerate the medication and that there were no adverse effects. A pain audit in recovery showed 100% of patients in February 2016 had their pain assessed, recorded and managed appropriately.

- Patient comfort surveys were used in the endoscopy department to monitor pain. These were carried out by the nurses and entered onto the electronic patient record system. Sedation was provided to patients to manage the procedure. Pain relief medication was given intravenously where needed.
- Patients discharged from the inpatient ward or following day case surgery were provided with analgesia to take home. This was prescribed during their outpatient appointment by the consultant. We saw information sheets provided to patients on discharge about their medication which provided information about the medication they were taking home, possible side effects, other important information and 24 hour telephone numbers to access help and advice if required.

Nutrition and hydration

- Processes were in place to assess and monitor and meet patients' nutrition and hydration requirements. Patients' nutritional needs were assessed and recorded using a recognised assessment tool, the malnutrition universal screening tool (MUST). This information was recorded on the patient electronic record system. We also observed evidence and care plans detailing individual nutritional status contained in patient records.
- The treatment centre provided a variety of well-balanced meals that catered for a variety of different diets. We saw the menu provided to patients on a daily basis to make their meal choice.
- There were protected meal times (when visitors were not allowed) in place for patients on the ward. This gave staff more time to ensure patients were sat out in a chair during mealtimes and more time to support patients eating.
- Patients were encouraged to stay hydrated. Water bottles were within reach on the table by the bedside and refilled regularly.

Patient outcomes

- The treatment centre took part in the national Patient Reported Outcome Measures (PROMs) for the reporting period October 2014 to September 2015. PROMs are standardised, validated question sets that measure patient's perception of health, functional status and their health-related quality of life before and after surgery. The answers to these question sets weresubmitted to a national database which analysed the effectiveness of the care delivered to patients as perceived by the patients themselves. PROMs audits were completed for patients who had hip or knee replacements, groin hernia surgery and varicose vein surgery. The treatment centre scored above the England average for hip replacement surgery and varicose vein surgery. Knee and groin surgery performance was within the expected range for the England average.
- The Oxford hip and knee score was a questionnaire that measured symptoms and function before and after a patient having a joint replacement. For 396 people who participated in the questionnaire for hip replacements between April 2014 and March 2015, 98.2% of people reported an improvement in their function.
- The Aberdeen varicose vein questionnaire measures the health status for patients after varicose vein surgery. Out of 61 patients who completed the questionnaire between April 2014 and March 2015, 82% reported an improvement in health status.
- Patient outcomes from endoscopy were followed up by telephone call. A nurse from endoscopy telephoned the patient between 24 and 72 hours post-procedure. The call reviewed how the patient was feeling and managing post-procedure. The information was then entered onto the electronic patient recording system.
- Patients had post-operative support to maximise recovery and optimise progression with function and mobility prior to discharge home. The physiotherapy service was provided twice-daily to patients and mobility aids were provided to maximise independence whilst on the ward.
- Physiotherapy follow-up care was provided at two weeks, six weeks and one year post-operation to review patient outcomes following surgery. The physiotherapy team felt continuity of care was important and tried to

ensure patients saw the same physiotherapist at follow up appointments. Referrals could also be made to out of area physiotherapy services most suited to the patient depending upon their location.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients. Specialist training took place for staff in each department. This included in-house training for theatre staff about pre-assessment training and management of the deteriorating patient. Resident medical officers also had individual specialist training sessions with consultants around common operative procedures carried out at the treatment centre. This was to make them aware of common complications and outcomes of specialist surgical procedures to prepare them for this eventuality.
- A resident medical officer told us they were well supported with development and training. They were given a one-month induction on joining to undertake all training either face to face or via e-learning. They told us the anaesthetists provided training around airways and critical care management and that advanced life support training was provided externally.
- Specialist training was available for staff in theatres. A training matrix was given to new members of staff working in recovery and theatres that demonstrated their competency to provide safe care and treatment to patients whilst working in the department. Staff competencies were reviewed by managers on a yearly basis.
- Staff were encouraged to develop their knowledge and skills to improve the quality of care provided. There was a training folder where staff could request further training. Staff were supported to do this if they had completed their mandatory training. Training outlined in the personal development portfolio (PDR) was usually granted. Further justification was required before training was approved if further training was not recorded in the PDR. The medical director told us there was a generous budget for training which helped with staff retention.
- Staff were trained to use specific pieces of equipment within their department. Nurses and health care assistants HCAs in endoscopy were trained to use the automated endoscope reprocessors (AER's) decontaminators. AERs are high level disinfectors for endoscopes. The training was provided by the manufacturer and yearly updates were also available for staff to ensure their competence and safety in using the equipment.
- There was a system in place to monitor medical revalidation. Medical revalidation was launched in 2012 to strengthen the way doctors are regulated. The aim is to improve the quality of care provided to the patients, improving patient safety and increasing public and patient confidence and trust in the medical system. We reviewed the medical revalidation folder held by the medical director. The file contained a summary sheet detailing the last date of the doctor's personal development review, the due date for the next review and who was responsible for completing the evidence records.
- There was a system in place to ensure consultants only carried our surgery they were skilled and competent to perform and that they continued to maintain their competencies to practice. Score cards were used as part of the appraisal process for the medical staff. These were shared with the NHS employers to ensure a joint approach to medical staff competency was maintained and upheld.
- The appraisal rate for the medical staff at the treatment centre October 2014 and September 2015 was 100%. Two staff members told us they were supported to put their profile together and had essential data provided by the Emersons Green treatment centre.
- Staff at the treatment centre had yearly appraisals carried out by department managers. The appraisal for staff across theatre and the ward was 100%.
- Staff were given time to get involved with additional external training with South Western Ambulance Service NHS Foundation Trust. A simulation day using an ambulance and crew practiced the treatment centres patient transfer protocol, preparing the patient and transferring them to the ambulance. The treatment centre staff also had the opportunity to experience what it was like caring for a patient in the back of a moving ambulance with the lights and sirens in action.

Multidisciplinary working

Good

Surgery

- There was evidence of effective multidisciplinary working. We observed a multidisciplinary team preparing for a ward round. The team included the consultant, ward manager, physiotherapist and resident medical officer. The team reviewed X-rays and discussed patients' progress in preparation for the ward round.
- Members of the multidisciplinary team were supportive of each other's roles and responsibilities. The physiotherapist gave us an example of times when they worked closely with the nursing staff to optimise patient care and experience whilst making the best use of resources and time.
- We observed multidisciplinary theatre briefing and debriefing checklists that were completed daily. All members of the theatre team that day attended both briefing sessions. Staff were able to provide feedback and rate their satisfaction with the theatre list and the events that day. This information was reviewed at a weekly meeting. Staff told us they felt this was a good team-building exercise.
- There was effective early discharge planning for patients which started at the pre-operation assessment stage and involved all members of the multidisciplinary team. One physiotherapist told us that expectations were discussed and goals were set with the patient to encourage independent management and progression on discharge. These were communicated to other staff looking after the patient to ensure a joined-up approach. A physiotherapist also assessed what equipment was required on discharge and engaged with the relevant external services promptly to avoid discharge delays.
- The patient experience co-ordination team worked closely with the patient and multidisciplinary team to co-ordinate patient care prior to admission for a procedure. Blood results were reviewed by the team and abnormalities were highlighted to the patient, GP and the anaesthetist who were then called upon to advise about further investigation and treatment.
- Information was shared with GPs on discharge from the service. Nurses completed the discharge summary and a final assessment summary was completed by the resident medical officer on the electronic record system. A discharge letter was then created and a further information sheet detailing medication and follow-up instructions was sent to the GP.
- Handover forms were completed and transferred with the patient during each stage of their journey from pre-operation to theatre, theatre to recovery, and recovery to the ward. The handover form required the admitting staff and the receiving member of staff to sign when the handover had taken place. A verbal handover was provided in addition to the written form. Nursing staff from theatre and the ward told us they had been involved in improving the form to ensure all important information was handed over. We were told this process worked well.

Seven-day services

- The treatment centre did not provide seven day surgery lists but did provide medical and nursing treatment and care 24 hours a day, seven days a week. Surgery was booked Monday to Saturday 8am to 4pm.
- Physiotherapy provided a seven day service cover where patients were seen twice daily.
- Patients' clinical care was the responsibility of the consultant 24 hours a day, seven days a week. There was access to medical cover seven days a week, including out of hours cover and weekend cover. Out of hours there was a consultant on call for each speciality and an anaesthetist on call out of hours and over the weekend. There was also an anaesthetist based in the outpatient department during working hours to attend to emergencies or deteriorating patients on the ward. Resident medical officers told us there was good consultant support and they could call consultants whenever needed to escalate concerns. Resident medical officers worked 12 hour shift patterns seven days a week. They provided cover for routine clinical treatment and would escalate urgent clinical treatment as appropriate.
- The treatment centre had urgent access to imaging and reporting. We were told that patients could be transferred for urgent computed tomography (CT) or magnetic resonance imaging (MRI) scans at the Royal United Hospital, Bath. MRI scans could also be carried out through the contracted services at Emersons Green treatment centre.
- Seven day pharmacy cover was provided at the treatment centre to support staff. Pharmacists were available six days a week during working hours with an on call service available outside these times. There was

an on call pharmacist rota providing pharmacy input outside of working hours. We were told by the pharmacist that most calls out of hours were to provide advice to staff.

Access to information

- The treatment centre used an electronic patient record system. All staff had access to this system to obtain patient information and to document case notes. Staff told us the system took some time to get used to, but once experienced was reasonably easy to use to access information. In the event this system failed, paper-based records were readily available to ensure care and treatment could continue.
- Discharge summaries were sent to the patient's GP. Comprehensive summaries were sent electronically by email. This helped to avoid a delay in follow-up care required on discharge.
- GPs had direct access to resident medical officers for advice using the 24 hour telephone hotline. They were connected to the resident medical officer on duty to provide support or advice.
- There was a system in place to share information with external services where patients were referred. Referral letters were written by the consultant making the referral. In endoscopy, we were told that if patients required a follow-up procedure they chose at that time where they would receive this treatment. A referral summary was sent directly to the relevant hospital and also to the patient's GP informing that the referral had been made.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff acted within the legal framework to obtain patient consent for treatment. Patients gave consent for their procedure twice; once at the pre-operation stage and again on admission to the theatre. Consultants always obtained consent from patients and provided information about the operation, outcomes and possible complications. This enabled the patient to make an informed decision. We observed completed written consent forms in theatres. The forms were signed and dated by patients. These were stored in patients' notes.
- Training had been provided to staff around gaining consent for young people aged 16 and 17 years old. Staff received training about the Gillick competence (a tool used in medical law to decide whether a child is able to consent to his or her own medical treatment, without the need for parental knowledge or permission). Staff were educated about the encouragement of the young person to disclose any information that may affect the anaesthetic or procedure, information about what to expect and the differences encountered when dealing with young people. The same consent paperwork that was used for adults was used for young people.
- There were processes in place which demonstrated and recorded patient consent was obtained for joint replacement surgery. The National Joint Registry (NJR) looked at patient information between January and April 2016.The treatment centre had carried out 377 joint replacements, 158 hip replacements and 219 knee replacements. The evidence of consent was recorded as 100%, which exceeded the NJR target of rate of 95%.

Are surgery services caring?

Good

We have rated surgery at Emersons Green NHS Treatment Centre to be good for caring because:

- All the feedback we received from patients about the service was continually positive. Patients felt they were treated with dignity and respect and valued their interactions with the staff.
- The staff demonstrated a caring approach by the way they interacted and communicated with patients.
- Patients told us their family were involved as partners in their care. Patients felt able to raise questions and concerns and felt they were always responded to in a positive way and received information in a way they could understand.

Compassionate care

- There were good interactions between staff and patients. Staff communicated clearly, made good eye contact and got down to the patient's level if they were sat down to engage better in conversation. Staff paid full

attention to the patient during all interactions. We observed clear follow-up advice being provided in a compassionate manner to a patient during the gynaecology ward round.

- Staff on the ward were committed to providing person-centred care and treatment. Patients told us they felt staff communicated well, provided clear explanations and gave them encouragement and the opportunity to ask questions. People we spoke with described staff on the ward as "kind, attentive and helpful". One person told us how they felt they were "treated as a person, not just a number," whilst another told us "nothing is too much trouble".
- Privacy and dignity was maintained at all times. Patients gave examples of staff knocking on the door and asking for permission to enter the room and ensuring dignity was maintained by closing curtains and doors when appropriate. We observed the physiotherapist arrive to collect a patient for physiotherapy. The physiotherapist made sure the patient was comfortable and that their legs and catheter bag were covered before leaving the patient's room. A patient led assessment of the care environment (PLACE) was completed for the reporting period of February to June 2015. The PLACE score for privacy and dignity was 97%, which was better than the England average of 87%.
- Staff promoted independence and normality on the ward. Physiotherapists provided patients with walking aids and encouraged independent movement and mobility within a safe environment. The physiotherapy team worked with patients to build their confidence and optimise progress.
- The friends and family test data showed good results. Patients were asked to say if they would recommend the treatment centre to their friends and family. From April to September 2015 the percentages of patients who said they would recommend the treatment centre ranged from 98% to 100%. In February 2016, 100% of patients said they would have recommended the hospital to friends or family.

Understanding and involvement of patients and those close to them

- Patients were involved with their treatment and care. Patients told us they were encouraged to ask questions and play an active role in their care and treatment. Patients we spoke with said staff always asked if they had any further questions before they left the room and took the time to answer questions and explain information in a way that could be understood. We saw one consultant taking the time to answer questions and support a patient to make important decisions about care and treatment
- Staff communicated well with patients and understood their individual needs. We observed the pharmacist visiting a patient on the ward to discuss medication. The patient was anxious about a specific medication requirement and some side effects post-surgery. The pharmacist reassured the patient that their individual needs around their medication would be met. The pharmacist then took the time to explain the side effects of two particular medicines taken by the patient. This explained the patient's experience post-surgery. The pharmacist gained consent to discuss this further with the patient's GP.
- Patients we spoke with told us how staff communicated with them and took the time to explain what they were doing and why. We were told by one patient that a member staff spent time explaining the importance of managing pain. Following this the patient had a better understanding of how and why it was important to manage pain effectively.
- Patients told us how their family members had been involved in all aspects of their care and decision making from pre-operative assessments through to discharge.

Emotional support

- Staff recognised and supported patient anxieties throughout their journey through the treatment centre. One patient told us they had telephoned the ward prior to their admission to discuss concerns they had around their procedure. They felt the nurse understood their condition and anxieties and had provided very reassuring advice. This had helped put the patient at ease to come in for the procedure.

Good

Surgery

Are surgery services responsive?

Good

We have judged the responsiveness of the surgery service as good because:

- The treatment centre worked with local Clinical Commissioning Groups, GPs and the patient forum group to plan and develop services for the local population.
- Services were flexible to meet the needs of the population and planned to ensure continuity of care from department to department.
- The surgical department had taken the needs of the patients into account and removed barriers to enable complex patients to access care.
- Complaints and concerns were taken seriously and used to make changes to improve care and patient experience.

Service planning and delivery to meet the needs of local people

- The treatment centre worked in conjunction with local Clinical Commissioning Groups (CCG's) and other stakeholders, including GPs, to meet the needs of the local population. There were regular meetings with local stakeholders and the senior management team told us they had a good relationship with the local CCGs. Referrals to the treatment came from several commissioning groups with Wiltshire CCG being the highest referrer during the financial year of 2015. There had been a recent reduction in the number of GPs referring to the treatment centre. A survey had been sent to the local GPs to gain an understanding of why this was the case.
- The treatment centre was keen for the local public to understand what services they had to offer the local population. An open day had recently been held and members of the public were invited to visit the treatment centre and look inside all the departments and theatres and talk with staff.
- Patient forum members provided an active patient-centred voice around service planning and delivery. The forum members were invited to attend regular governance meetings to put forward ideas and issues raised by patients in order to improve services. The patient forum told us that senior management were very receptive of the ideas put forward and that they had an open and transparent relationship with the team.
- Theatre opening times provided flexibility and choice for the local population. Theatres were open Monday to Saturday 8am until 4pm and the recovery unit only closed once the last patient had left the department.
- Services were planned to ensure continuity of care was provided when patients were moved from department to department and provided a seamless transition for patients between services. Communication between theatres and recovery ensured effective service delivery and safe transition of patient care. A member of the theatre team informed the recovery nurses 15 minutes prior to the patient being ready to transfer from theatres to the recovery department. This gave the recovery department time prepare for the arrival of the patient.
- Services were responsive and kept patients informed when there was a problem with service delivery. There was good communication with patients and between departments when theatre was running late. We observed the daily theatre list with the expected times of patient operations reported. If theatre ran late for a day case patient, the manager or deputy theatre manager contacted the patient directly, explained the problem and informed them of a new arrival time. Patients who had already arrived for their operation would be spoken with directly by the theatre manager who would apologise for the delay. The patient would be provided with a new theatre time. Patients were also given the option to wait on the ward where there was access to more comfortable chairs and a television until theatre was ready. If the patient was on the ward, the ward staff would be contacted by the theatre team to inform the patient of the new operation time.
- Facilities in the theatre admission area were responsive to the patient's needs for the service that was planned and delivered. Day case patients were provided with personal lockers to store any valuables in whilst they were in theatre. This provided reassurance that their belongings were safe whilst they were in theatre.

- Patient feedback cards and letters were on display in reception. One card suggested having the café open on a Sunday due to no food or drink being available. Next to the feedback the hospital had displayed a card informing patients that as a result of the feedback, tea and coffee was now available in the café on a Sunday for comfort and convenience.

Access and flow

- People could access care and treatment at a time to suit them and actions were taken by the theatre manager to minimise the waiting times for patients. There were four operating theatres each operating Monday to Saturday between 8am and 4pm. The theatre manager would call patients in advance to inform them of an arrival time to minimise their wait. If theatre was delayed on the day, the patient would be contacted to rearrange their arrival time to avoid them waiting at the treatment centre.
- The treatment centre was meeting its referral to treatment target (RTT) waiting times. Between the reporting period of October 2014 to September 2015 the treatment centre scored 100% for its RTT against a target of 90%.
- Technology was being used to enhance the delivery of care and treatment. An electronic tool was used in theatre to capture data about the working day. The tool provided a visual measurement about how well theatre days were run and provided a full picture of how services were operating. Data was recorded about theatre utilisation and turnaround times, and was also used to audit theatre delays. This was clearly displayed on a large monitor in theatres for all staff. A project team met with the head of clinical services, theatre manager and deputy theatre manger weekly to analyse data and identify action plans to improve performance. We reviewed the minutes from one of these project meetings, which included action plans to reduce delays and ensure operation lists did not overrun.
- The treatment centre had variable theatre utilisation and productivity rates. This was reviewed on a weekly basis during the scheduling meeting which was attended by the senior managers and lead anaesthetist. Theatre utilisation for March 2016 ranged between 34% for ophthalmology to 86% for orthopaedics, with its overall productivity ranging between 30% to 86%. Senior hospital managers told us about the current low referral rates from GPs and NHS trusts due to a lack of understanding about what the treatment centre can provide. Further work was needed to establish better working relationships with local NHS trusts and GPs to increase referral rates.
- Arrangements were in place to ensure timely discharges outside of pharmacy working hours. Pre-labelled stock was available for patients outside of pharmacy working hours. There was a local service level agreement with a local pharmacy where patients could access their medication.
- The majority of cancelled surgery was due to unavoidable clinical reasons, such as patients being unwell on the day of surgery. There had been 237 clinical cancellations on the day of surgery between March 2015 and March 2016. Cancellation data was captured monthly and avoidable cancellations were discussed regularly at mortality and morbidity meetings and speciality meetings. During the year to date, all procedures had been rebooked within five days which met the treatment centre's target.

Meeting people's individual needs

- Patents were provided with an information guide on admission to the treatment centre that gave essential information for patients. The guide covered privacy, waiting times, how to make a complaint, infection control, how to avoid slips, trips and falls, information about staff, visiting hours and food and nutrition. There were also copies of the guide located around the ward for reference.
- A 24-hour telephone hotline number was provided to all patients on discharge to provide ongoing support. Patients could call the helpline 24-hours a day, seven days a week and speak to the most relevant member of staff to get support or advice regarding concerns or problems following surgery. During inspection we observed two hotline referrals to resident medical officers. As a result of the call, the patients were asked to return to the treatment centre on the same day for further assessment.
- There was a dedicated theatre and recovery team on call overnight with consultants for each speciality and anaesthetists who would come in if a patient needed to be brought back to theatre. Theatre readmissions were

discussed at consultant speciality meetings and mortality and morbidity meetings to determine any actions to be taken in the future to prevent further readmissions with the same problem.

- Services were planned, co-ordinated and delivered to take into account patients with complex needs to optimise care, treatment and access to services. A member of staff told us how the endoscopy department supported a patient with learning difficulties. Staff told us how the patient and family were brought in the week before, given a tour of the department, shown the specific rooms and areas and had the procedure explained. This was to help reduce anxiety on the day. On the day of the procedure, staff allowed a family member and carer into the procedure room to help settle the patient. They were then waiting once the procedure had finished.
- Services were planned and tailored to meet individual patient's needs. We were told about a situation where treatment protocols were adjusted to meet the needs of a patient with learning difficulties. A multidisciplinary team meeting was held between the patient, carer, surgeon, anaesthetist, recovery lead and governance lead to discuss concerns about treatment. A new individual plan for care and treatment was set up for the patient to meet their individual needs and also ensured that anxiety was kept to a minimum on the day of the procedure. Theatre staff ensured the patient was allocated the same nurse from admission through to recovery. This ensured continuity of care to help reduce anxiety. A carer was also allowed to come into the recovery area to support the patient after the procedure.
- Adjustments were made to accommodate patients living with learning difficulties, dementia or complex needs if they were required to stay overnight on the ward. Family members or carers could stay overnight with patients. On these occasions, a reclining chair was brought into the patient's room so the relative or carer could sleep more comfortably.
- The inpatient ward had developed a room which was tailored to meet the needs of patients living with dementia to promote their independence. This room had a red frame around the toilet and a red toilet seat to identify the bathroom and the toilet and a red clock to help with time orientation.
- Translation services were available for patients. These services could be booked through reception or were organised at pre-operation appointments. We were told staff never relied on family members to translate for patients. This was to ensure the patient was provided with all of the correct information to make an informed decision.
- Patients under the enhanced recovery programme were provided with an exercise booklet and a demonstration of the exercises. Patients were also made aware of the Care UK smartphone application that provided post-operative exercises and advice
- Special shorts were provided for patients in endoscopy to maintain dignity. Patients were also covered with a blanket to ensure their dignity and that they remained warm throughout the procedure.
- Patients were empowered to maintain communication with those close to them. There was a telephone by each bedside. Patients were able to make free telephone calls to landlines or UK mobile phones. Relatives were able to gain direct telephone contact with patients through the hospital switchboard.

Learning from complaints and concerns

- Patient concerns and complaints were used to improve the quality of patient care and the service provided. The hospital had policies and processes in place to appropriately investigate, monitor and evaluate a complaints. In 2014, the treatment centre received 29 complaints. An acknowledgement of the complaint was provided in three working days and a full response provided within 20 working days in the majority of cases.
- The hospital director oversaw the complaints process and ensured complaints were dealt with by the most appropriate staff member. Complaints were discussed at senior management meetings, heads of department meetings, departmental meetings and at clinical governance meetings. Complaints were also discussed during monthly quality assurance meetings. These were attended by all clinical and non-clinical staff. Actions and learning points from the investigation were explained to staff to ensure shared learning and improvement for the future.
- Leaflets and posters were available around the hospital informing patients about how to make a complaint.

Leaflets were also translated into different languages and therefore accessible to all. We were told about a complaint that had been made by a patient about communication issues with a member of staff. The senior management team met with the patient to apologise and arranged for a new appointment to be made with a different consultant to continue treatment.

- The endoscopy department told us how feedback had resulted in a change in the service. Feedback was obtained twice a year via the joint advisory group audit. Feedback demonstrated how patients would like a choice as to whether music was played during their procedure. As a result the department started giving patients a choice about music being played during a procedure. Patients were able to bring in their own music or choose from a selection in the department.
- None of the patients we spoke with had any complaints about the service. All comments we heard and read on the feedback board in the reception area were very positive.

Are surgery services well-led?

Good

We have judged the leadership and governance for the surgical service as good because:

- The treatment centre had a challenging, yet achievable, vision and strategy that staff were aware of and involved with achieving.
- Work was actively ongoing with external stakeholders to help deliver the vision and strategy, and to provide the best service for patients.
- The senior management team were an enthusiastic, committed team delivering safe, patient centred care. Staff and patient engagement was embedded in the culture at the treatment centre.
- There were strong governance processes at all levels in the treatment centre, with a monthly quality assurance meeting attended by all clinical and non-clinical staff, as well as the patient forum.
- There was a strong focus on improving quality of care and patient experience.
- The vast majority of staff spoke highly of the working culture. Senior management were visible, approachable and engaged with staff.

However:

- There were occasions when staff felt overwhelmed by the senior management team and felt their work and decision-making was not trusted.

Vision and strategy

- There was a corporate vision and strategy for the treatment centre which was to ensure the patient was at the heart of the service. The vision included focus on ensuring high quality, integrated care, innovation, effectiveness and efficiency. Staff were familiar with the vision and strategy and understood their role and responsibility in achieving it. Staff were also familiar with the values for the organisation and we saw these posted on walls around the treatment centre.
- There was a clear vision and strategy to integrate the treatment centre into the wider health community. The overall focus was to ensure quality and safety as a priority. The treatment centre's vision concentrated on the need to integrate into the health community and break down barriers between primary and secondary care to improve referral rates and provide greater choice for patients. A survey had been sent out to local GPs to understand their concerns about referring patients to the treatment centre. We were told about a plan to achieve better regular communication with the local GPs and NHS trusts and to provide better education around what the treatment centre could provide for patients in the locality.

Governance, risk management and quality measurement for this core service

- There was an effective governance framework in place to monitor performance, risks and outcomes and provide safe, good quality care. Key governance, risk and quality information was fed from senior management to frontline staff and vice-versa on a monthly basis.
- The senior management team held a governance meeting at the start of each month. The medical director, hospital director, head of nursing and governance manager met monthly to discuss incident

reporting, clinical data, risk registers and other issues that had arisen over the past month. Important aspects were drawn out to feed back to staff during the monthly quality assurance meeting.

- A monthly quality assurance meeting took place for all clinical and non-clinical staff. Clinical activity was cancelled to ensure all staff could attend, with the exception of care for patients on the inpatient ward. All staff were made aware of important information that had arisen from the directors' clinical governance meeting and actions that were to be implemented following incidents or complaints. Issues such as infection control, patient outcomes, complaints, incidents and new guidelines were also discussed to keep all staff informed and updated.
- There were surgical speciality team meetings held on a monthly basis, responsible for reviewing surgical procedures and practice. We observed the minutes from the orthopaedic speciality team meeting in January 2015. The meeting was used to discuss agreed practice and protocols in line with current best evidence and National Institute for Health and Care Excellence guidelines. Departmental issues, incidents, complaints, results from audit and clinical performance were also discussed. The minutes detailed the discussions that took place and any action or learning points taken from the discussion, and these were circulated to all staff.
- Staff told us they received feedback from clinical governance meetings attended by heads of department. Feedback was provided through team meetings and by email. Staff told us that if they had any issues, managers would raise these at clinical governance meetings on their behalf.
- There were robust arrangements to identify, record and manage risks and issues. Local risks were identified using the department risk register. Equipment breakdown was on the endoscopy risk register. There were actions in place to reduce the risk of equipment breakdown. These included quarterly checks of equipment and yearly maintenance checks. We were also told that some equipment could be delivered by one within one hour if required.
- There was a systematic programme of internal clinical audit which was used to monitor quality and identify where actions were needed to improve. For example, a local infection, prevention and control audit calendar was running in the theatre department. We observed the calendar and a copy of actions identified to improve systems and process to ensure quality and safety when the treatment centre did not meet their 90% target.

Leadership and culture of service

- Leaders were visible throughout the surgical department, often undertaking walks through the department. Staff told us they felt the senior management team were approachable and supportive. We were told the management team took the time to stop, engage and speak with staff, which helped them to feel respected and valued.
- There was a culture of openness and honesty and staff told us they felt comfortable to raise concerns with senior management and were encouraged to do this. There was a staff feedback box where staff could raise concerns anonymously. Staff could also feedback at staff forums.
- Teams worked collaboratively and constructively and shared responsibility to deliver good quality care. The theatre and recovery staff told us about their strong, open working culture and how they worked as a team to support each other. They told us as a team they had high levels of communication and a proactive approach to managing problems or concerns to ensure they did not escalate.
- There was a culture of openness, candour and honesty; however, we were told that a controlled drugs incident in June 2015 had tested the trust between members of staff in theatres. An independent coach was brought in to council and support staff through this time to help restore relationships, trust and team working. Senior management explained how they tried to ensure they were open and honest with staff and kept them informed of the investigation process. Senior management were open and honest on reflection about how they managed some areas of the investigation and recognised where they could have been more supportive of staff.
- Good practice was rewarded on a monthly basis. Staff could nominate other staff members to receive an award for good practice. Emails were sent to staff detailing who had been nominated and why. Emails were then sent to all staff identifying who had won the award. Staff members who won were also given a badge

to wear as a form of recognition. We saw several staff members wearing their recognition badges. Five members of staff were awarded monthly. We were also told that some members of staff were recognised for the wider Care UK awards on a yearly basis.

- Staff felt able to raise concerns internally. We were given an example of a concern raised by a member of staff about another member of staff. The member of staff about whom the complaint was raised was spoken with and asked to produce a written reflection on the incident. The member of staff who raised the concern was also provided with feedback and assured that the situation had been dealt with appropriately and resolved.
- It was apparent that some staff perceived there to be an element of mistrust and control from the senior management team. Staff at times felt there was an element of micromanagement in the form of immediate escalation of all issues, problems or concerns that could be effectively dealt with at departmental level. Staff told us they found this "challenging" and felt that senior management placed unrealistic and unachievable targets on departments at times. However, staff told us when this was the case, they were able to talk with senior management and felt they were listened to. We were told the senior management team had high expectations of the standards of care and treatment. Staff felt this was the reasoning behind the oversight and control. Despite this, staff felt confident to communicate and challenge management when they felt it appropriate.
- Staff told us it had taken time to build up trust and working relationships with senior management. They told us they were starting to feel more autonomous and this was bringing about a positive cultural change in the centre.

Public and staff engagement

- Staff were involved in local department meetings to improve service quality and delivery. A monthly staff meeting was held for the theatre department. An agenda was put up on the notice board for staff to add topics for discussion. The meeting was chaired by the theatre manager or deputy theatre manager and aimed to resolve concerns raised by staff and address issues around practice in the department. However, if concerns were complex, the head of clinical services was asked to attend. We were given an example of a change made after concerns were raised about high demands being placed upon staff during a particular theatre list. The concern was taken to the senior management meeting and actions put in place to better support staff during this list. We were told that if there was a specific concern raised by several members of staff before the monthly meeting, managers and staff would get together to deal with the concern before it escalated. Staff meetings were held at the end of the theatre list so that staff could attend. The minutes were also emailed out to staff.
- Staff were actively involved in working groups to help plan to improve quality and safety for patients. Working groups were set up to address areas of practice that required continual improvement to optimise patient safety. We observed minutes from the most recent falls and VTE working groups detailing discussion points and action plans. Staff were also involved in setting up local national safety standards for invasive procedures (NatSSIP's). The NatSSIP's set out key steps necessary to deliver safe care for patients undergoing invasive procedures and allowed organisations delivering NHS-funded care to standardise the processes that underpin patient safety. We were told there were several groups set up with multidisciplinary involvement. One member of staff led each multidisciplinary working group.
- Staff were encouraged to get involved and take on additional roles and responsibilities at the treatment centre to shape service development and improve quality. Link nurse roles were set up and specific members of staff with a particular interest were encouraged to become involved. These roles aimed to develop practice and introduce new pathways which led to safer patient care. These link roles included infection, prevention and control. Staff were also involved in working parties for venous thromboembolism (VTE) and falls. We observed minutes for the VTE working party detailing issues, actions and a named person responsible to carry out each specific action.
- Patients were encouraged to give their views and feedback to support service improvement. The patient forum met quarterly and also held events to encourage patient and public involvement. A tea party was held on Macmillan day in September 2015 and there was a patient and public forum stand available at the recent

treatment centre open day. Quarterly meetings were held between the patient forum and senior management and they are also invited to the monthly governance meetings to share feedback. We were told management were proactive in taking action from patient feedback and were provided with an example about recent replacement of floor signage to make it more visible and readable for patients.

Innovation, improvement and sustainability

- Individual medication information sheets were provided to patients on discharge with a clear summary of the medications they were being given, their uses, what they do and possible side effects that might be experienced.
- Following new recommendations from the Association of Anaesthetists of Great Britain and Ireland a neuromuscular blockade monitor had been purchased to safely monitor the effects of anaesthesia during operations and recovery.
- Some practice and working processes had been recognised by other hospitals. We were told by senior management that a team from University College London Hospital had recently visited the theatre department and had taken away action plans and learning points in order to develop in their own theatre department.
- The treatment centre had worked very closely with a Welsh hospital at the start of 2016 to reduce their surgical waiting list times for patients. The treatment centre had provided coach transport and lunch for these patients, and put on extra surgical lists on a Sunday to accommodate the patients.
- The treatment centre worked closely with the University of the West of England and South Western Ambulance Service to provide placements for student paramedics to practice and develop advanced airway skills.
- The treatment centre provided teaching sessions to trainee surgeons from the Royal United Hospital, Bath in ophthalmology and in the past, ear, nose and throat. Trainee surgeons accompanied consultants into the operating theatre during the teaching sessions. Theatre lists were reduced on training days to ensure time was taken to provide good quality training.
- Staff were given time to get involved with additional external training with South Western Ambulance Service. A simulation day had been put on with an ambulance crew and ambulance attending the treatment centre to practice patient transfer protocols. The treatment centre staff had the opportunity to experience what it was like caring for a patient in the back of a moving ambulance with the lights and sirens in action.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Emersons Green NHS Treatment Centre provided outpatient and diagnostic services to NHS-funded patients at its purpose-built facility, which opened in 2009. These services included a range of general and specialist imaging procedures including plain X-rays, dental X-rays and ultrasound. An external company using a mobile unit provided magnetic resonance imaging (MRI) once a week. There was a 10 room outpatient department (nine consulting rooms and one treatment room) holding up to eight clinics a day across specialties such as orthopaedics, oral surgery and ear, nose and throat (ENT), for up to 15 hours a day. In 2014, at the request of the Bristol Clinical Commissioning Group, the hospital extended its referral age range to include young adults from the age of 16.

The hospital served a local population and accepted referrals from NHS trusts and GPs in the south west region. On average, the outpatient department received over 1,000 new referrals each month. In October 2015 the hospital received 1,372 new referrals across all specialties. Between October 2014 and September 2015 the hospital held 35,053 outpatient appointments, of which 22,771 (65%) were follow-up appointments. The other 12,264 (35%) were first appointments. The hospital also provided satellite services for cataract surgery for an NHS trust in Wales. Between January 2015 and December 2015 the diagnostic imaging department performed 4,615 plain film X-rays, 3,187 ultrasound examinations and 1,793 dental X-rays.

During our inspection we visited the general outpatients department, ENT, orthopaedics, ophthalmology, urology, gynaecology and oral surgery clinics and the physiotherapy outpatient department. We also visited the diagnostic imaging department, including ultrasound and plain film.

We spoke with 21 patients, relatives and carers. We also spoke with 25 members of staff including managers, clinical (doctors, nurses, allied health care professionals and health care assistants) and non-clinical staff.

Good

Outpatients and diagnostic imaging

Summary of findings

Outpatient and diagnostic services at Emersons Green NHS Treatment Centre were rated as good overall. We found:

- There were good systems in place for incident reporting and learning when things did not go as planned.
- Systems were in place for the safe administration of medicines and for the prevention of infection.
- Staff were knowledgeable about safeguarding and their responsibilities to vulnerable adults.
- Staff were knowledgeable about their duty of candour towards patients.
- Staff were very competent in the roles they were being asked to perform.
- There was good multidisciplinary working within the hospital.
- Staff captured data about patient outcomes, and used it to make changes to the way they worked.
- Staff communicated in a professional but friendly manner with patients and their families.
- Comments from patients and relatives were extremely positive about the staff and how they provided their care and treatment.
- Patients were involved in their care and treatment and their needs were always put first. The hospital put patients at the core of the services they delivered.
- The departments provided a good service to make sure people were not waiting long periods of time for either outpatients or diagnostic services.
- We saw the hospital was achieving all of its referral to treatment standards across all specialties.
- We saw evidence that complaints were discussed at departmental and higher level meetings and changes were made where necessary to help improve services and prevent further complaints.
- The hospital welcomed all feedback from patients, and made changes to services if necessary.
- Staff were supported at all levels, from their immediate manager through to the hospital executive team, including the hospital director.
- Good governance systems were in place across outpatients and diagnostics.
- The majority of staff we spoke with felt the culture was open and that staff strived to make sure the experience for patients was outstanding in line with the hospital's values and vision.
- The hospital engaged with the patient forum and used them to help develop services.

However:

- The hospital target of 90% compliance with mandatory training in January 2016 had not been met in outpatients or physiotherapy. In particular, only 80% of diagnostic imaging staff had completed basic or intermediate life saving training.
- Some staff described the style of management of some senior managers as overpowering, although we did not find this view shared by the majority of staff.
- Diagnostic imaging staff did not always follow up urgent results with GPs.
- The electronic patient record system was prone to slow down, and the hospital had identified a risk should it stop working completely.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated the safety of the outpatient and diagnostic imaging services to be good. This was because;

- There was a good incident reporting culture amongst staff, which was reflected in the consistent numbers of incidents reported in the hospital between October 2014 and September 2015. Learning from serious incidents and root cause analyses was shared with the whole Care UK organisation.
- The design of the hospital was sufficient to keep people safe at all times, with waiting areas free from obstructions and providing staff with good visibility of patients at all times.
- There was a good process for monitoring controlled drugs and breakages, including unannounced inspections of controlled drugs log books.
- Patient records were generated and stored electronically, so they were available across the whole Care UK organisation.
- There was a good understanding of safeguarding from all staff. We saw policies were up to date and staff were aware of recent changes.
- Staff in the hospital all received 'Prevent' training to detect and prevent radicalisation of staff or patients.
- Staff had been on a course run by a local ambulance trust in the management and identification of a deteriorating patient.
- The hospital held twice yearly reviews of staffing levels, based on the hospital activity and referral levels.
- There was a roaming anaesthetist based in the outpatient department, who was available for emergencies and to help manage deteriorating patients.
- The outpatient and diagnostic imaging departments had 100% compliance with hand-hygiene audits.

However;

- The hospital identified a need for better communication between consultants and a clear system to flag urgent referrals.
- The diagnostic imaging department only had one X-ray cassette reader, which would mean there would not be an on site X-ray service if it broke down.
- The hospital target of 90% compliance with mandatory training in January 2016 had not been met in outpatients or physiotherapy. In particular, only 80% of diagnostic imaging staff had completed basic or intermediate life saving training.
- We saw sediment on a patient water dispenser and staff did not know if flushing of the dispenser took place, and could not produce any records of this.

Incidents

- Safety performance over time was good when compared to other similar services. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them both internally and externally. Staff consistently reported incidents and the treatment centre had some of the highest numbers of incidents, concerns and near misses reported when compared to other similar organisations within Care UK. Between October 2014 and September 2015, the hospital recorded 320 incidents. Staff told us this was because of an open reporting culture. Examples of incidents reported included medication near misses, short staffing, patient falls and missed staff breaks.
- Staff reported incidents on a Care UK-wide electronic incident reporting system. All staff we spoke with could describe how to access and use the system, although some staff said it could be a bit difficult to use when trying to categorise incidents, as the standard categories did not always reflect the incidents.
- Staff described how they used the incident reporting procedure for all incidents that had potential to affect patient care, including staffing shortages.
- Safety goals had been set. Performance against safety goals was monitored using information from all Care UK sites. An annual quality account presented the hospital's quality objectives for the coming year, based on the information gathered the previous year. For example, quality objectives in relation to safety in the outpatient

and diagnostic imaging departments were to improve the reporting of medication incidents. Between April 2014 and March 2015, Emersons Green NHS Treatment Centre reported 224 medication incidents, which included a high number of pharmacy interventions on prescriptions where information was incorrect or missing. This was the highest number of medication incidents reported across all the organisations benchmarked. The objective was to increase reporting because the risk of potential harm could be reduced through improved training and supervision, and did not therefore necessarily signify that more errors were being made at the treatment centre.

- Between October 2014 and September 2015 the hospital reported four serious incidents, three of which related to outpatients. Two examples included: in February 2016 a serious incident investigation took place into a delay in treatment or care of a patient. In June 2015, a patient attended for a hysteroscopy following some post-menopausal bleeding, but was found to have a cardiac condition which doctors felt was a priority. The patient did not have the hysteroscopy until January 2016, when it was found their original condition had deteriorated. A root cause analysis (RCA) took place and several factors were identified as causing the delay. Appropriate learning and actions were taken to prevent a similar incident reoccurring.
- Thorough and robust investigations were carried out when things went wrong in the outpatient and diagnostic department. Lessons were learned and actions put in place to improve services. However, staff told us senior managers always carried out investigations, and staff in the actual departments often had little to no involvement until the investigation had been completed. Lessons learned were always shared to ensure action was taken to improve safety beyond the affected team or service. For example, the hospital had reviewed its urgent pathway for post-menopausal bleeding, and concluded it was not sufficient to prevent patients from experiencing unacceptable delays in care or treatment. As a result, the hospital removed the option to refer post-menopausal bleeding from the NHS Choose and Book service. The hospital wrote to all of the GPs in the area to inform them of this decision and also the reasons why. The hospital shared the learning with the Care UK group, including its other hospitals and treatment centres, via a shared learning tool, which was accessible to all of the hospitals and treatment centres. Staff also told us they received either electronic or verbal feedback from incidents reported. Incidents were discussed at monthly staff meetings, and we saw the minutes from these meetings which were stored in a folder for staff to access.
- The hospital was participating in a Commissioning for Quality and Innovation (CQUIN) which set the hospital pre-agreed quality and innovation goals. This allowed the hospital to actively engage with its commissioners. The hospital had met these goals, which included a temporary CQUIN to look into the use of the National Reporting and Learning system (NRLS) for the reporting of serious incidents. Independent hospitals currently cannot report serious incidents in the same way as acute NHS hospitals, and a local CCG had begun looking into changing this in the future.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires the provider to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. Most staff could explain what the Duty of Candour meant, and gave examples of conversations which had taken place following a moderate harm or serious incident. We were told these conversations were always carried out by the senior hospital managers, and did not involve staff from the areas affected.
- We saw evidence of this regulation being applied, for example following an incident involving a controlled drug. The incident had identified a number of vials of a pain killer which had looked suspicious to staff. An external consultant carried out a root cause analysis investigation and two internal consultants carried out a subsequent audit of patient pain levels. Two patients were identified who may have been affected by the controlled drugs. Both patients were invited to meetings at the hospital to discuss the investigation, how the incident may have affected them, the actions being taken to prevent a recurrence and for apologies to be given.

Cleanliness, infection control and hygiene

Good

Outpatients and diagnostic imaging

- Staff explained how standards of cleanliness and hygiene were maintained. We saw evidence that cleanliness and hygiene checks were regularly carried out, and looked at up to date cleaning logs in both the clinical and public areas of the clinics we visited, which showed regular cleaning was taking place. All the equipment we saw was visibly clean.
- The hospital reported compliance with the Care UK national housekeeping infection control policy into the monthly red flag dashboard, which showed in December 2015 95% compliance in the outpatient department, 99% in diagnostic imaging, and 100% in physiotherapy.
- We saw the hospital was visibly clean and tidy, and patients said the hospital was "spotless".
- Patient-led assessments of the care environment (PLACE) had been completed regularly across all outpatient and imaging areas. Within these assessments, areas were checked against cleanliness quality standards and given a rating of pass, qualified pass or fail. All the areas we looked at had passed.
- Staff could explain the importance of good hand hygiene and also the limitations of alcohol gel. The hospital had set a hand hygiene compliance target of 100%, and regularly monitored and improved these systems when required. In November 2015, the outpatient department had 100% compliance with hand hygiene. We saw hand washing practices taking place before and after patient contact. All staff we saw followed the hospital's infection prevention and control policy by observing the 'bare below the elbow' rule.
- Staff were unable to show us any records of flushing in relation to a patient water dispenser in the main waiting area, and we saw hard sediment had formed on the dispenser. Tap flushing is important to help prevent water-borne bacteria, for example Legionella and Pseudomonas aeruginosa, from forming in water supplies.
- Personal protective equipment was available for staff, and infection control measures were in place, when a consultation or scan was carried out on a potentially infectious patient. Staff told us infectious patients did not come down to the outpatient department, and remained in isolation on the wards until they were no longer infectious.

Environment and equipment

- Facilities and premises were designed in a way that kept people safe. The main reception waiting area was very bright and spacious, and reception staff had a clear view of the entire area. However, we noticed the area could become quite cold if the main doors were open for any length of time. Staff told us there was a warm air heater, but it was very noisy and prevented them from hearing patients clearly at the reception desk.
- The hospital footprint limited options for expansion. Staff told us clinical departments and storage facilities were nearing capacity. A review of storage and stock ensured excess stock was not being stored on site unnecessarily. Senior staff told us about plans to recruit a dedicated staff member who would be responsible for stock management.
- Systems were in place to ensure the use and maintenance of equipment kept people safe. The hospital maintained equipment according to manufacturer's instructions and tested it for electrical safety. Stickers on each piece of equipment showed when they were due to be tested again. We saw up to date maintenance logs for all the equipment we looked at.
- There were safe systems for managing waste and clinical specimens. For example, because pathology and microbiology services were provided externally off the hospital site, there was a secure utility room where patient samples were stored until collected by a dedicated courier.
- Resuscitation equipment was readily available, and staff we spoke with could all identify where their nearest resuscitation trolley was located. Emergency trollies and bags were available in both radiology and outpatient areas. These trollies were tamper-proof by means of security tags. The trollies and bags were checked on a regular basis and we saw evidence to confirm these checks took place. Each emergency trolley had an emergency medicines box that had already been checked and sealed by the pharmacy department. If the seal was broken, staff returned the box to pharmacy and received a replacement. We looked at four trollies and found all the equipment and checks were in date and a tamper-proof tag was intact.
- The imaging service carried out thorough risk assessments for all new or modified use of radiation. These risk assessments addressed occupational safety as well as consideration of risks to people who used services and members of the public. All risk assessments

were held within the department, and reviewed annually. The department had participated in a Diagnostic Reference Level (DRL) audit in September 2015, which had shown all ionising radiation equipment to be within acceptable limits. This was performed by staff with the support of the radiation protection advisor (RPA). Dose reference levels were used to help radiology staff assess if they were using the correct amount of radiation to examine each part of the body.

- The diagnostic imaging department had one X-ray cassette reader, which, if it broke, would not allow X-rays to be taken in the department. Theatre X-ray screening could continue independent of this reader. At the time of our inspection staff told us this had not been risk assessed, but a business case was being put together to replace the equipment within the next 12 months. Staff told us in the event of a complete breakdown, they would speak to the outpatient clinics, who would call patients to rearrange appointments before they left for the hospital. Alternative imaging facilities were available at another near by hospital in the Care UK group.
- The imaging service ensured that non-ionising radiation premises, in particular magnetic resonance imaging (MRI) scanners, had arrangements in place to control the area and restrict access. The main access to the diagnostic imaging department was via secure double doors. Patients had to ring a door bell to gain access, and were escorted to the X-ray room, ultrasound room or visiting MRI scanner by a member of staff.

Medicines

- The hospital had a medicines management policy, and this provided safe systems for reporting breakages of controlled drugs and their disposal. Staff reported all breakages on the incident reporting system, and recorded it in the controlled drugs log book. A pharmacist destroyed broken vials returned to pharmacy, witnessed by the hospital director. Systems for managing medicines were reliably communicated to staff, and were monitored and reviewed when required. For example, following a serious incident, a review of controlled drug procedures took place. Staff found that auditing of the controlled drugs book, and the number of breakages of controlled drugs vials had been recorded but had not been passed on to senior managers for review. Audits had shown a spike in the number of breakages of a certain controlled drug. As a result of the investigation into the incident, monthly audits of controlled drug checking were introduced, along with a detailed disposal procedure. The pharmacy manager also did unannounced random controlled drug register checks.
- The systems in place for monitoring and maintaining stock levels and rotation did not make tracing medicines throughout the patient journey very easy, but did keep patients safe. Staff told us the computer system currently used was designed for a retail setting so pharmacy staff therefore used a written diary to track medicines, their use and to identify spikes in the use of any particular medicine. Staff were confident they could track any medicine using this diary and the invoices sent by the manufactures, which were stored in both paper and electronic versions. Staff told us they were concerned about the computer system and this had been escalated to the hospital risk register. The register included mitigating actions, for example regular stock checks, monitoring of monthly medicine usage, and manual medication checks with the invoices when medicines arrived at the pharmacy.
- In the outpatient department, staff told us patient 'to take out' medicines (TTOs) were pre-ordered by the consultants at the patient's first appointment, which could be days or weeks before the patient's planned procedure. Pharmacy prioritised the TTOs based on date and urgency. Screening of the orders took place one to two weeks before the patient came in, and were signed off by the pharmacist and dispenser. Pharmacy staff told us they had to adjust some prescriptions when they vetted the orders. For example, sometimes allergy information was missing. Errors were broken down by consultant, and a detailed email was sent informing them of the pharmacy intervention. Details about interventions were collated and reported into the monthly clinical governance meeting. There had been 224 medication incidents or near-misses reported between April 2014 and March 2015, which included pharmacy interventions on all prescriptions in the hospital. Staff told us they thought doctors did not always look at referral letters when they wrote patient TTOs, and this was a factor when allergy information was missing.
- We looked at how medicines were stored in a selection of outpatient departments and found they were stored appropriately in locked cupboards that only staff had access to. Where necessary, refrigerators were available. Refrigerator temperatures were checked on a daily basis

to make sure the medicines were being stored at the correct temperature. Staff explained that if a refrigerator was outside of its temperature range, they would contact pharmacy for advice or guidance.

- There were systems in place to ensure the safety of controlled drugs in outpatients. We reviewed how controlled drugs were stored, and found these were locked away separately, checked by two members of staff and recorded in a dedicated controlled drug record book. We did not see any medicines stored inappropriately or that were out of date.
- All resuscitation trolley medicines checklists we looked at were up to date, and all of the medicines we looked at were within their usage dates.

Records

- Patients' individual care records were accurate, complete, legible, up-to-date and stored securely. We saw secure, locked filing cupboards behind manned reception desks where records were stored. Records were only taken from this cupboard at the start of a clinic, and were returned at the end of the clinic.
- Emersons Green NHS Treatment Centre did not have access to patients' full NHS medical records; however, they did receive a referral letter with an agreed minimum data set for all patients. Patients were assessed against admittance criteria using the referral letter from the GP, which included all relevant medical history. The patient then completed a health questionnaire. This information was available for use throughout the patient journey – both electronically and in paper format.
- There were systems in place for managing records and these were communicated to staff. Patient records were generated for each first appointment after the triage stage. The triage team requested additional information from the referrer as appropriate before the outpatient assessment. Referrals from the GP were scanned onto the computer database system. This system held all patient records, including integrated care pathways (ICP) for specific specialities and procedures.
- There was a reliable system for ensuring medical records were available for clinics, for example, in the event of a computer failure hard copies of all referral documents and minimum data sets were available in patients' paper notes. The staff on each late shift printed referral documents for the following day in case there was a system failure overnight. The paper record remained on-site until the patient was discharged, at which point it was scanned into the computer system before being securely archived. There was an agreement with the archiving company to obtain copies of paper records in an emergency situation.

Safeguarding

- Safeguarding policies and processes ensured people were kept safe. All staff we spoke with could clearly describe the safeguarding procedure and name the safeguarding leads. All staff knew how to contact one of the safeguarding team and we were given examples from various clinical and non-clinical staff of situations where they had contacted the safeguarding team for advice. In particular, we were told of a patient who had attended an outpatient appointment with a black eye. The reception staff had asked what happened, found cause for concern and then contacted the safeguarding team, who then raised a safeguarding alert with the local authority
- There were arrangements in place to safeguard adults and young adults from abuse that reflected the relevant legislation and local requirements. Staff understood their responsibilities and adhered to safeguarding policies and procedures. We saw a folder containing advice for staff covering various safeguarding situations, including what to do if they had a patient they suspected may have been subjected to female genital mutilation.
- The safeguarding lead had introduced a workshop to raise awareness of 'Prevent' for new and existing staff to help identify signs of radicalisation in both staff and patients. Prevent was part of the government's counter-terrorism strategy and aimed to stop people becoming terrorists or supporting terrorism. Prevent focused on all forms of terrorism in a pre-criminal space, and provided support and re-direction to vulnerable individuals at risk of being groomed into terrorist activity before any crimes were committed.
- All staff we spoke with had been trained in safeguarding adults. However, at the end of January 2016 some departments were not 100% compliant with their mandatory training requirements in this area. Seven out of 21 departments had not met the hospital target of 95% compliance, including outpatients (90%). However, some managers told us they did not think the records were up to date for their departments.

- We saw advice leaflets about adult abuse displayed on patient information stands throughout the outpatient and diagnostic imaging departments.
- There were processes in place to ensure the right person received the right radiological scan at the right time. The radiologist in diagnostic imaging vetted all referrals. When they were not available, another radiologist was available remotely to look at referrals. Staff told us if anything was unclear, such as confusion around the side to be examined, staff approached doctors directly to discuss the referrals before performing the X-ray. The diagnostic imaging manager had started monitoring the quality of X-ray referrals, in particular the number of requests with the incorrect side for examination. There was no data available to review at the time of inspection as the project had only just begun.
- The diagnostic imaging department regularly audited the compliance of referrals under the Ionising Radiation (Medical Exposures) Regulations 2000 (IR(ME)R), and fed the data into the hospital's governance processes. Data showed good compliance.

Mandatory training

- Staff received regular mandatory training updates across 27 subjects including basic, intermediate and advanced life support, safeguarding adults, child protection and manual handling. Most staff were up-to-date with their skills and knowledge, which enabled them to care for patients appropriately. The hospital set a target for 90% of staff to be up to date with this training. At the end of January 2016, 90% of outpatient staff were compliant with their mandatory training requirements, 93% of diagnostic imaging staff and 89% of physiotherapy staff. In outpatients, the topics where the number of staff who had completed their training were below target included manual handling (76%), infection control (85%) and medicines management (74%). In diagnostic imaging only 80% of staff had completed their basic or intermediate life support training update. The manager told us a patient had recently fainted in the department and some staff had not been confident in their response to this incident. This had highlighted a training need for some staff so some bespoke scenario-based training had been arranged to take place at a future date.
- Staff told us training was delivered in face to face sessions, and also online, and they felt the training was of a good level to ensure the safety of patients.

Assessing and responding to patient risk

- The radiation protection advisor (RPA) was offsite in London and accessible by telephone or email. This presented a risk in the event of them being unobtainable; however, there were no examples of this having been an issue. The manager in diagnostic imaging told us that when they had started in their role, they had been supported by the RPA in developing and reviewing the Ionising Radiation (Medical Exposures) Regulations 2000 (IR(ME)R) procedures.
- The imaging services had appointed radiation protection supervisors in each clinical area, who were working closely with the manager to develop and lead the quality assurance programme for equipment. Quality assurance was carried out on a weekly and monthly basis to highlight any problems that might affect the quality of X-rays taken.
- The imaging service ensured that requests for an X-ray, MRI, or other ionising radiation diagnostic test, were only made in accordance with IR(ME)R. Staff had a list of approved referrers, and checked this when a request was accepted for vetting. Any discrepancies were referred to the radiologist.
- There were adequate signs and information displayed in the radiation department waiting area informing people about areas and rooms where radiation exposure took place. The design of the department meant it was not possible for a patient to get in without being let in by a member of staff, as the doors had a swipe card access system.
- The imaging service ensured women (including women using the services and female staff) who were, or may be, pregnant always informed a member of staff before they were exposed to any radiation, and we saw signs which advised patients to do this on the waiting room walls and X-ray room doors. Where pregnancy was a possibility, patients were asked if they were pregnant and asked to sign a form if they were not. If there was any doubt over a patient's pregnancy status, the X-ray was not performed and the radiographer spoke with the radiologist for advice.
- There were clear pathways and processes for the assessment of people within outpatient clinics or the diagnostic imaging department who were clinically unwell and required hospital admission. Staff were aware of these pathways and had the opportunity to complete a course run by a local ambulance service, in

conjunction with the hospital anaesthetics department. The course covered pre-operative assessment and recognising the deteriorating patient. Staff told us that if a patient became unwell, they would call for help from nursing and medical staff.

- There was a floating anaesthetist based in the outpatient department who acted as resuscitation lead for the hospital and was available in emergency situations or to help identify and manage deteriorating patients. Staff we spoke with knew how to contact this anaesthetist in an emergency.
- In the event of a patient becoming acutely unwell and needing to be transferred to an acute NHS hospital, staff called 999 to get emergency assistance from the ambulance service. Staff we spoke with were aware of this policy and could describe when they would use it.
- There were clear protocols in place for managing challenging behaviour in the outpatients or diagnostics departments, and staff were aware of these protocols. However, staff we spoke with could not recall when they last had a patient who had become aggressive. A senior manager told us that they had been contacted on one occasion to attend the outpatient department when a patient threatened to harm a doctor. The doctor had withdrawn from the situation, and the senior manager assisted to calm things down. The manager investigated the problem, and the patient was assigned to another consultant.

Nursing and allied health care staffing

- Staffing levels and skill mix ensured people received safe care and treatment at all times. Staff numbers were planned and reviewed every six months and were based on the hospital's activity levels. The National Institute for Health and Care Excellence (NICE) safer staffing guidelines were used to help establish planned staffing levels throughout outpatients and diagnostic imaging, and the hospital had participated in the trial to develop the guidelines. The hospital had developed its own outpatient staffing model, which planned staffing allocations six weeks in advance, and was based on planned activity in the clinics.
- During our inspection, staff told us the senior managers were very responsive to staffing levels, and in physiotherapy staff told us when they reviewed their activity levels, if more staff were required, the managers responded and adjusted the staffing model.
- Both agency and permanent staff received a comprehensive induction to the outpatients and diagnostic imaging. Agency staff received some generalised training from the agency they represented, and induction training from the hospital. Permanent staff received a hospital induction.
- During the period October 2014 to September 2015, the outpatient services used some bank nursing staff during six of the 12 months, and only one agency nurse. The total number of bank nurses as a percentage of overall staff peaked at 14% in August 2015. During the same period, the hospital used allied health care bank staff in 10 of the 12 months, with a maximum usage of 18% in March 2015.
- Senior staff told us that where possible they always tried to fill staffing vacancies with bank staff rather than agency staff. This was because bank staff were familiar with the hospital and its policies and procedures.
- Staff in diagnostic imaging told us they had a regular agency staff member, who had been working at the hospital for over a year, who was familiar with the hospital's policies and procedures.

Medical and dental staffing

- The hospital employed 37 consultant doctors and dentists, and planned and reviewed staffing levels and skill mix so that people received safe care and treatment at all times. Staffing levels were reviewed every six months, taking into account activity levels in the hospital.
- The hospital was entirely consultant led, which meant at outpatient appointments, patients saw the consultant rather than a junior doctor.
- There was one full time radiologist and another radiologist available remotely when they were not available.
- Planned staffing levels for each clinic were determined based on the activity in the clinic, and allocated on a six-week rolling rota. Consultants were available in outpatient clinics Monday to Saturday, 7am to 9pm.
- The hospital had an arrangement with a local District General Hopsital that enabled trainee junior doctors to come to the hospital and gain experience and training in ophthalmology, alongside the consultants.

Good

Outpatients and diagnostic imaging

- Medical staff told us they had additional support from on-call services in physiotherapy, pharmacy, radiology and facilities. Consultants also sought advice from consultants from a nearby acute NHS trust via the telephone.
- The hospital ensured that main employers of consultants working as 'bank' surgeons received feedback. Senior staff told us that these consultants had scorecards created for them containing details of their competencies, any incidents and complaints. These scorecards were then shared with the consultant's main employer.

Pharmacy staff

- Pharmacy staff told us out of hours and overnight support was provided by one person, and had been for the past number of years. In their absence, the head of nursing provided support instead. While this presented a potential risk if the on-call workload was high, the pharmacy manager told us they were contacted infrequently so this did not have an adverse impact on them.

Major incident awareness and training

- There were reliable arrangements in place to respond to emergencies and major incidents. Staff could describe how to summon help in an emergency situation with a patient, and told us the hospital policy stated to dial 999 for an ambulance. The hospital regularly reviewed these systems.
- When the hospital made changes to the service or the staffing arrangements, the impact upon safety was comprehensively assessed. For example, the hospital monitored its referrals and activity levels on a monthly basis, and reviewed planned staffing and clinic usage every six months to ensure the correct number of staff were allocated. In physiotherapy, sustained increased activity levels had led to the appointment of more permanent staff.
- By using bank staff the hospital was able to temporarily increase its staffing numbers at short notice, in response to service demands or unexpected staff shortages.
- There were effective arrangements in place in case of a radiation incident occurring. The diagnostic imaging department had a good quality assurance programme for equipment to prevent and identify any fluctuations in the radiation output of equipment both in the department and in theatre. Staff told us if the figures were outside of the tolerance range, they would call the RPA for advice and stop using the equipment.

Are outpatients and diagnostic imaging services effective?

The effectiveness of outpatients and diagnostic imaging was not rated due to insufficient data being available to rate these departments' effectiveness nationally.

We found:

- The use of best practice was evident throughout the outpatients and diagnostic imaging services.
- Staff felt their training was good and provided them with the necessary skills and knowledge to perform their role.
- Multidisciplinary working was in place to ensure efficient patient care.
- Diagnostic imaging was available seven days a week to inpatients within the hospital.
- The report turnaround times in radiology for plain film were 24-48 hours and one week for ultrasound.
- There was an enhanced recovery programme in physiotherapy which allowed physiotherapists to capture complex data six weeks after a patient's procedure.
- The outpatient department provided evening and weekend clinics in all specialities.
- The hospital used approved national surveys to capture patients' outcomes, including the use of a dedicated survey for patients with learning difficulties.

However:

- Diagnostic imaging staff did not always follow up urgent results with GPs.
- Computer systems used to store images and reports were different throughout the Care UK diagnostic imaging centres and other NHS trusts. This meant images had to be sent over to the computer and transferred by a staff member to the patients' electronic folder. We were told images were not always readily available because this was not always done.
- The electronic patient record system was prone to slow down, and the hospital had identified a risk should it stop working completely.

Good

Outpatients and diagnostic imaging

Evidence-based care and treatment

- The outpatient and diagnostic imaging services incorporated relevant and current evidence-based best practice guidance and standards. These were used to develop how services, care and treatment were delivered. For example, the hospital's standard operating procedure for methicillin-resistant Staphylococcus aureus (MRSA) screening reflected the National Institute for Health and Care Excellence (NICE) clinical guideline 139 and advice from the Department of Health's expert advisory committee. Only patients coming in for certain procedures, such as joint replacements, had preoperative swabs taken.
- The outpatients and diagnostic imaging services were able to show evidence that they used NICE guidelines to identify and implement best practice. In the pre-operative assessment clinic, staff told us they referred to the NICE guidelines for preoperative tests for elective surgery clinical guideline 3, and we saw this embedded in the standard operating procedure (SOP) for the clinic. Staff we spoke with were all aware of the SOP, and told us they would consult it for advice and guidance if they were unsure which tests they needed to carry out.
- The outpatients and diagnostic imaging services ensured that discrimination was avoided when making care and treatment decisions. For example, the hospital had taken part in a Commissioning for Quality and Innovation (CQUIN) project, commissioned by the Bristol Clinical Commissioning Group (CCG), which required them to meet a set of standards that met the requirements of the Equality Act 2010.
- The imaging service used diagnostic reference levels (DRL's) as an aid to optimisation in medical exposure. Staff were able to locate and explain how they used these as a tool. These levels were audited in September 2015, and were within acceptable limits. DRL's were a way of making sure staff used the right amount of radiation to image each body part.
- The diagnostic imaging service did not always follow NICE guidelines for acting on urgent radiologist reports. Senior staff told us they did not always follow up urgent results with GPs after the report had been sent through, so the department was not receiving assurance that prompt action was being taken.
- The diagnostic imaging manager had recently undertaken an audit of image quality of a type of dental X-ray called an orthopantomograms (OPGs), and as a result had arranged training on positioning techniques, which had improved the consistency and quality of the images.
- Pharmacy showed us they included a hyperlink in their intervention emails for doctors, which reminded doctors of their responsibilities under NICE clinical guideline 183, for the diagnosis and management of adverse medicine reactions.
- The outpatient service ensured outpatient procedures, such as cystoscopies, were carried out in line with professional guidance. For example, in urology we saw evidence of NICE guidelines used to develop pathways for patients having certain urology investigations.
- Staff showed an understanding of the rights of people subject to the Mental Health Act and had regard to the MHA Code of Practice. However, some staff said that they did not have many patients attend with mental health problems, because of the hospital referral criteria.

Pain relief

- The level of pain in adults was assessed using a simple one to five comfort scale. Staff said it was unusual to have to ask patients in outpatient clinics to rate their pain; however, all staff demonstrated a good understanding of methods available to them for management of patient's pain. All of the patients we spoke with were comfortable and had their pain adequately controlled.

Nutrition and hydration

- Patients' nutrition and hydration needs were being assessed and met. During our inspection we saw water fountains throughout all the outpatient areas we visited, and staff demonstrated a good understanding of the importance of assessing nutrition and hydration needs.
- As part of the services provided at the hospital, patients were told to allow up to two and a half hours for their appointment, as a lot of specialties tried to provide a one-stop service. Where unexpected or long delays in these clinics happened, patients were given complimentary vouchers for tea and coffee from the hospital canteen.
- As a result of patient feedback, the hospital had introduced some gluten free biscuits to the hospital canteen menu.

Good

Outpatients and diagnostic imaging

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected and monitored. Staff were involved in activities to monitor patient outcomes, such as completing Oxford questionnaires in physiotherapy at patients' one year follow-up appointments. This information showed the physiotherapy staff how people were progressing by assessing them over several areas, including their physical progress and also aspects of their social life.
- The outpatient and diagnostic imaging services participated in local audits and benchmarking, such as through the Care UK comparative performance data report. The hospital also collected data about the outcomes in cataract surgery. The target of 91% of patients regaining driving standard vision had been exceeded at Emersons Green NHS Treatment Centre, with 92.6% of patients regaining driving standard vision between April 2014 and March 2015.
- Outcomes for people in this service compared favourably to other similar services in the Care UK organisation. Outcomes for people using outpatient or diagnostic imaging services had improved over time. Data indicated that Emersons Green NHS Treatment Centre was achieving four of the five Care UK quality indicators in outpatients and diagnostic imaging. The target for reducing the number of operations cancelled due to clinical reasons had not been met between April and December 2014. The target was less than 1.5%, and Emersons Green NHS Treatment Centre had 1.6% of operations cancelled due to clinical reasons.
- The physiotherapy department used information about people's outcomes to assess the effectiveness of the patient's treatment. Staff used a spreadsheet to track the progress of patient treatment, including any adverse or unusual symptoms the patient may have experienced. Action was always taken to make improvements as a result of the outcomes of the audits and benchmarking. For example, if the physiotherapist had any concern, they referred the patient back to their consultant for review, or they called a multi-disciplinary team meeting.
- Staff also told us they sent out follow-up letters to patients to see if they had needed any additional healthcare following treatment or care at the treatment centre. This data was fed into another CQUIN about continuity of care; however, the response rate had been very low.

Competent staff

- All staff administering radiation were appropriately trained to do so. Those staff who were not formally trained in radiation administration were always adequately supervised in accordance with the Ionising Radiation (Medical Exposures) Regulations 2000 (IR(ME)R).
- All staff had the right qualifications, skills, knowledge and experience to do their job and these were regularly reviewed and updated. Staff were given the opportunity to develop new skills to allow them to undertake additional activities. For example, the diagnostic imaging department had identified a need for a full time sonographer because direct referrals had increased. In addition to recruiting a suitably qualified sonographer, an existing member of staff was also being supported to undertake the post-graduate diploma in ultrasound.
- The learning needs of staff were clearly identified using an end of year performance and development review, where managers and staff set clear learning objectives for the coming year. Staff told us that managers worked closely with staff to achieve these goals. All staff received appropriate training to meet their learning needs. Staff told us they were encouraged and given opportunities to develop, and could discuss training ideas with their mangers. Staff told us they had been encouraged to go on courses that would benefit their role or department. For example, one member of staff in the outpatient department had just finished a level three direct care diploma.
- There were reliable arrangements in place for supporting and managing staff. These included study sessions which had been developed to help registered nurses with their revalidation. Some staff we spoke with had attended these sessions and found them very useful.
- Poor or variable staff performance was identified and managed appropriately through regular staff meetings. Staff were supported to improve through a variety of methods. For example, senior managers told us they held monthly one to one meetings with managers, and set clear goals and objectives along a set timeline.

Good

Outpatients and diagnostic imaging

- In January 2016, 100% of staff had all received their annual appraisals.

Multidisciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment. Any member of staff at any time could call a multi-disciplinary team (MDT) meeting to discuss any concerns.
- Care was delivered in a coordinated way when different teams or services were involved, and all staff worked together to assess and plan ongoing care and treatment in a timely way. This included when people were due to move between teams or services, including referral and discharge. For example, staff told us if a patient was found to have a condition which excluded them from being treated at Emersons Green NHS Treatment Centre, a consultant letter was always sent back to the patient's GP, which included recommendations for the GP to follow. Consultants sent patients back to their GPs in the first instance because they were not allowed to make consultant to consultant referrals.
- The imaging service always attempted to make use of previous images for the person requiring the test, even if these had been taken elsewhere. For example, a patient attended for a procedure and the diagnostic imaging department had the patient's previous images imported onto the hospital X-ray computer system for the consultant to look at.
- The diagnostic imaging service ensured it met clinical guidance for report turnaround times for medical staff requesting diagnostic imaging to be carried out. This included plain film and dental X-rays, ultrasound and MRI. The department provided a direct access service for GP referrals for ultrasound and MRI. Most plain film X-rays were reviewed by the referring consultant on the day they were taken, and reported by the radiologist in the following 24-48 hours. The radiologist reported ultrasound within one week, and the external MRI company turned reports around and sent them back to the hospital within one week. The hospital radiologist reviewed the MRI results before sending them on to the referring GPs, to identify any urgent results. At the time of the inspection, there was no backlog of reporting. Staff did not audit report turnaround times, however, they told us there had never been a backlog. Times and dates of reports were easily accessed if there was a discrepancy, and senior managers told us staff monitored outstanding reporting as part of their daily tasks. Work was currently underway to write report monitoring into a standard operating procedure for the department.
- One-stop clinics involving different disciplines of staff working together were available in most clinics, including orthopaedics, ophthalmology, urology and ear, nose and throat. When pathological samples had to be sent away to a local NHS trust for testing, the patient experience coordinators monitored results returned to the hospital and contacted patients to arrange follow up appointments.

Seven-day services

- The outpatient and diagnostic imaging service operated six days a week, Monday to Saturday, from 7.15am to 9pm, and provided a range of appointments and access to diagnostic imaging services.
- There was an overnight and Sunday on-call radiographer to cover any emergency plain film or theatre imaging.
- Pharmacy cover was available overnight and on a Sunday.

Access to information

- The information needed to deliver effective care and treatment was not always available to staff in a timely and accessible way. In diagnostic imaging, the computer system used to store images and reports was different throughout the Care UK diagnostic imaging centres and other NHS trusts. This meant images had to be sent over to the computer in advance of a patient's appointment. When images arrived, they had to be moved into the patient's correct electronic folder. We were told images were not always available in a timely way because this was not always done.
- When patients moved between teams and services, including at referral, discharge, transfer and transition, the information needed for their ongoing care was always shared appropriately and in a timely way. For example, if a patient transferred their care to another hospital, a full set of notes was printed for the patient to take with them.
- The systems that managed information about patients supported staff to deliver effective care and treatment. For example, all records generated for and about a patient during their care and treatment at the hospital were held electronically, and were available throughout

the hospital. However, staff told us they always printed records the day before a clinic, just in case the system went down. Staff told us the system was very good when it worked, but that it was prone to slow down, although it had never stopped working completely. This was a risk identified by the hospital, and it was on their current risk register.

- The outpatient and diagnostic imaging service provided electronic access to diagnostic results for X-rays, ultrasound and MRI on the computer system. Pathological results were processed off site at a local NHS trust, and results were sent back to the trust via a computer system. The resident medical officer (RMO) checked this system daily and alerted the patient experience coordinators to any returns. The patient experience coordinators then retrieved the results from the system and made appointments with patients so they could come in and receive their results. The external NHS trusts also sent paper copies of all results.
- Senior staff told us they did not always follow up urgent results with GPs after the report had been sent through, so the department was not receiving assurance that prompt action was being taken.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff demonstrated understanding of consent and the Mental Capacity Act 2005.
- The process for seeking consent was monitored by a regular audit programme and improvements had been made, such as providing staff with additional training to improve the quality of the consent process. In January 2016, data showed 100% compliance with the consent process in the outpatient department.
- Patients were adequately supported to make decisions. For example, a senior manager told us they had received a complaint from a patient who had not been happy with the information given to them in their consultation. The manager met with the patient, and arranged for a meeting to take place one evening so the patient's relatives could also attend. The patient was told by staff they did not have to consent to any treatment until they were completely satisfied with the information and explanation they received, and had asked all the questions they wanted to.
- Patients' mental capacity to consent to care or treatment was assessed at the initial appointment and throughout the patient's journey, and these assessments were recorded in the patient's electronic notes.

Are outpatients and diagnostic imaging services caring?

Good

We found outpatient and diagnostic imaging services at Emersons Green NHS Treatment Centre to be good for caring. This was because:

- We received overwhelmingly positive feedback about staff and services from nearly all of the patients we spoke to, which was reflected in the number of cards and comment cards on display throughout the hospital.
- All staff demonstrated genuine compassion for the people in their care, which was embedded into the culture of the departments.
- Patients were seen as individuals and care was tailored to them, and explained clearly at each step of the way.
- Patients we spoke with had been actively involved in the planning of their care, and felt that this had given them additional confidence in the abilities of the doctors and nurses.
- All patients were given a 24 hour contact number based in the hospital to call at any time if they were concerned about any aspect of their care or condition.
- When care fell short of a patient's expectations, senior managers were quick to engage with the patient to find a solution.

Compassionate care

- Staff understood and respected patient's personal, cultural, social and religious needs. For example, staff told us about a patient who attended for an appointment and appeared unkempt. Staff raised their concerns and a multi-disciplinary team meeting was called to discuss the patient's needs. The patient was invited into the hospital before their surgery to discuss a post-operative care package to include personal care, which the patient was delighted with.

Good

Outpatients and diagnostic imaging

- Staff took the time to interact with people who used the service and those close to them in a respectful and considerate manner. For example, we saw a patient who had cataract surgery brought out to the main reception waiting area by a nurse, who helped the patient into a comfortable seat, and then sat with them, making sure they were alright, until their transport arrived.
- Staff felt confident to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes of other staff. There was a special pathway developed by the safeguarding team to raise concerns safely and confidentially about staff behaviours.
- Staff showed an encouraging, sensitive and supportive attitude to people who used services and those close to them. For example, we spoke with a patient who had attended a dental clinic with their 15 month old baby. We saw staff looking after the baby whilst the patient was having an X-ray. The staff had then told the patient that at their next appointment they would be having some sedation, so the patient had plenty of time to make arrangements for child care. However, it was not clear if those staff had received training to do this.
- We saw staff addressing patients by their name, and confirming what they preferred to be called. All of the staff we observed were polite, respectful and genuinely caring when speaking to their patients.
- We also saw a patient who had to administer eye drops following their procedure. Staff had identified that the patient may struggle with the small drop bottle, so a special piece of equipment had been given to the patient to take away to help with the drops. We saw the pharmacist come out into the waiting area with the equipment, and sit with the patient, and ask them if they wanted to go to a private room for a demonstration of the equipment. The patient chose to stay in the waiting area, where the pharmacist showed and helped the patient understand how to use the equipment safely.
- When patients experienced physical pain, discomfort or emotional distress, staff responded in a compassionate, timely and appropriate way. However, we spoke with one patient waiting for an ultrasound, who was becoming distressed by the discomfort from her full bladder required for the scan. Diagnostic imaging was accessed through secure doors, but once the patient had rung the doorbell a staff member quickly attended and assisted the patient with their pain.
- Staff made sure people's privacy and dignity was respected, including during physical or intimate care. All consultation rooms had engaged/not engaged signs, which staff told us they always looked at, and knocked if they needed to gain access. In all clinics we visited patients were always able to speak to the receptionist without being overheard. In the main waiting reception area there were notices asking patients to stand back from the desk to allow patients being seen some privacy. However, in the physiotherapy gymnasium curtains were used to separate treatment areas, so some conversations about patient care could be overheard. Staff were aware of this, and had started using solid screens to provide an auditory and visual barrier to maintain their patients' privacy and dignity.
- The chaperone policy stated that all patients should be offered a chaperone. Staff always ensured that patients were offered a chaperone when a member of the opposite sex was providing their care. Where possible, staff ensured this chaperone was the same sex as the patient. There were clear signs in the main reception waiting areas and in the outpatient waiting areas informing patients of chaperone availability. Each clinic had a chaperone designated each day, but in addition there was a roaming chaperone who could be called on if the designated chaperone was busy. Patients we spoke with said they had been offered a chaperone.

Understanding and involvement of patients and those close to them

- Staff always communicated with patients so they understood their care or treatment. For example, we spoke with a patient who was returning for results of a biopsy, and they told us staff had clearly explained the follow-up process to them. They also said that when the consultant was explaining the scan and test results, they had turned the monitor and explained what they were looking at, and what it might be. We were also told staff were very calm, and this had helped the patient cope with the situation well. However, a patient who attended for a dental appointment had misunderstood their appointment letter and was expecting to have sedation and had arranged for a friend to come with

them as they believed they would not be able to drive after their appointment. The patient was unhappy because both they and their friend had taken a day off work to attend the appointment but no sedation was used. A senior manager came and spoke with the patient and took a copy of their letter and apologised to the patient for any confusion. They asked the patient what they would like them to do, and offered to send a taxi for their next visit. They also gave the patient and their friend food and drink vouchers to use in the hospital canteen before they set off home.

- Staff made sure patients and those close to them were able to find further information and ask questions about their care and treatment. A staff member told us it was common for patients to ask questions to help them understand their treatment. A patient told us that following their consultation they were given plenty of time to ask questions, and had not felt rushed to leave the consultation. All patients were given a 24 hour helpline number if they were worried or unsure about any aspect of their care or treatment.
- Staff recognised when patients and those close to them needed additional support to help them understand their care and treatment. A patient told us they had come back to see their consultant as their planned knee operation had been cancelled because there was a concern raised by a staff member that the patient may have had an allergy. The patient told us they had tests and were back to get a new date for surgery. The patient and their daughter told us they were very confused and upset when the operation had originally been cancelled, but staff had been extremely supportive and had taken time to explain why they had decided not to operate. The patient and their daughter had been in tears initially, but told us staff stayed with them until they were ok. The patient's daughter said she had been nervous about leaving her parent in the hospital at first, but now she had seen how caring the staff were, she was happy to leave her parent in their care.
- Following their appointments, patients told us they understood how and when they would receive test results. An ultrasound patient told us staff had explained when to contact their GP for their results. Patients we spoke with all had either planned dates for surgery or follow-up appointments for outpatient clinics before they left the hospital. One patient told us "everything was amazing", and they did not know they would have everything done in one appointment. One patient said "I've seen my consultant, had an X-ray, seen the physiotherapist and had a date for surgery eight days from now".
- Patients were aware of the date of their next appointment and told us they received copies of letters sent between the hospital and their GP.
- Patients told us they knew who to contact if they were worried about their condition or treatment after they left hospital. One patient told us they were worried about their progress, and had rung the hospital on the 24 hour helpline number they were given to ask if their appointment could be brought forward. The on-call doctor spoke with the patient and told them to come into the hospital the next day, and did not question the patient's request. The patient had seen the consultant and had an X-ray, which they were waiting to then have reviewed by the consultant.
- We saw information regarding safeguarding from abuse displayed in several languages in waiting areas where patients would see it.

Emotional support

- Staff understood the impact a person's care, treatment or condition could have on their wellbeing and on those close to them, both emotionally and socially. Staff told us how important it was to them to get the right package of care for each patient, which was based on their individual needs. We were told of a patient who had attended a first appointment and had appeared to have neglected their personal care. A care package was put together to take into account the patient's personal care needs as well as their physical health needs.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. For example, as part of the referral criteria for the hospital patients with suspected cancer were not accepted; however, if scans or tests showed a suspicion of cancer, staff were able to deal with patients in a sensitive and timely way. One member of staff told us "I will not be rushed with my patients".
- Patients were empowered and supported to manage their own health, care and wellbeing and to maximise

their independence. For example, easy read sheets were being used by pharmacy to accompany patient's medicines when discharged, so the patients could manage their own medication at home.

- Staff discussed treatment options with patients and they were encouraged to be part of the decision making process. One patient told us they were fully involved in discussions around treatment options in the dental clinic, and the consultant had been very open about their concerns around some treatment options for the patient, which had given the patient confidence in the consultant.
- Staff provided patients who used services with information leaflets and written information to explain their condition and treatment plan, and we saw staff handing some of these out and discussing areas of relevance with the patients.

Are outpatients and diagnostic imaging services responsive?

Good

We rated the responsiveness of the outpatients and diagnostic imaging services as good, with some areas of outstanding practice. This was because:

- The hospital was meeting all of its referral to treatment standards and all waiting times for a first appointment were six weeks or less.
- The hospital was improving relationships with GPs in the community to understand reasons why referral rates had declined towards the end of 2015.
- The hospital used a pager system to alert patients when they were ready to go through to the clinic, and identified patients this was not appropriate for.
- Staff monitored and audited the length of time patients spent in each department during their journey through the clinics using a traffic light computer system.
- Staff volunteered to put on extra lists to help treat a group of patients from Wales. The hospital provided a coach to bring all the patients to the hospital and provided food for all patients.
- Where treatment or care had to be delayed or cancelled, the hospital supported patients and fully explained the reasons why and what would happen next.
- The hospital took all complaints seriously and investigated them. Where possible, managers offered face to face meetings with patients to discuss their concerns.
- Patients who had additional needs, such as those with learning difficulties, were offered extra support such as longer clinic appointments, and pre-procedure experience visits along with their relatives or carers.

However:

- The hospital did not have sufficient parking for all of its patients, and a patient told us their partner had missed their consultation because they could not park.
- Not all staff were aware of the electronic flagging system for patients with additional needs.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. Commissioners and relevant stakeholders, including local GPs, were involved in planning services. Information was sought from these groups to help plan the service provision at Emersons Green NHS Treatment Centre to ensure it met the needs of the local population.
- The services provided reflected the needs of the local population, and also supported the needs of populations from, or in, other areas. For example, an ophthalmology team from the hospital visited an NHS trust in Wales to perform cataract surgery on a regular basis.
- There were evening and weekend clinics held in all of the specialties, between 7.15am and 9pm, which patients told us was very convenient for them.
- The facilities and premises were appropriate for the services that were planned and delivered.
- Staff told us that up to 22 patients were booked in a day for a clinic, at 20 minute intervals. Staff said they did not rush, but the timings of appointments sometimes slipped.

Good

Outpatients and diagnostic imaging

- The environment of the outpatient clinics and diagnostic imaging department were appropriate and patient centred, with plenty of magazines, information leaflets in various languages and a bright well-lit area with a television. There was also a large colourful healthy living display in the main waiting area with information about support groups and lifestyle changes.
- Facilities for children in waiting rooms were not always adequate; however, the treatment centre did not accept referrals for any patient under the age of 16, so there were no paediatric patients in the hospital. The only children who came to the hospital were accompanying their parents.
- There was insufficient car parking available. There was limited on-site parking and alternative parking arrangements off site were not available. However, parking facilities for patients were free of charge. One patient told us that when she had come for an appointment her husband had not been able to come into the consultation because he had not been able to park. The lack of parking was an issue on the hospital risk register.
- Patients were given pagers so they could remain in the reception waiting area until their appointment time. At the time of their appointment the pager would vibrate to alert the patient to come through. This meant staff did not have to call patient's names out loud, and prevented crowding in the outpatients department. Many patients told us this was a wonderful idea. Reception staff told us that if they thought it was not appropriate to give a patient a pager, they informed staff and the patients were escorted straight through to the clinic.
- Patients were able to locate the outpatients and diagnostic imaging departments because these were clearly signposted and there were members of the reception team available to help.
- Information was provided to patients in accessible formats (such as large print and braille) before appointments, including contact details, a hospital map and directions, the consultant's name, information about any tests including the predicted length of the appointment and if any samples would be taken such as blood or urine.
- The outpatient and diagnostic imaging services actively engaged with patients, relatives and patient representatives to involve them in decision making about the planning and delivery of the service. For example, a patient told us their relatives had been able to go into their consultation and ask questions on the patient's behalf, because they were worried they would forget to ask something. However, we did see a relative ask to go through to a consultation with an elderly family member, which was refused by staff.

Access and flow

- People had timely access to initial assessment, diagnosis or urgent treatment. The hospital's waiting times for referral to treatment were consistently below the NHS England standard of 18 weeks.
- The advertised waiting times for first outpatient appointments at the time of our inspection were: six weeks for dental, five weeks for gastroscopy and ultrasound, four weeks for joints , ophthalmology and minor orthopaedics , and three weeks for general surgery , ear, nose and throat (ENT) , urology , colonoscopy and gynaecology..
- The advertised waiting times from first appointment to treatment were: nine weeks for gynaecology, eight weeks for urology, seven weeks for minor orthopaedics, six weeks for dental, four weeks for minor eye one-stop clinics, and three weeks for joints, general surgery, ENT and ophthalmology. . The hospital had a clear link on its website home page which took patients directly to the current live waiting times.
- Patients were often able to access care and treatment at a time to suit them. Patients told us they were offered a choice of appointments. Action was always taken to minimise the time people had to wait for treatment or care. For example, patients were told in their appointment letters to allow up to two and a half hours for their appointment, because the outpatient department provided one-stop access to as many onsite tests as possible. A member of staff told us they monitored the length of patients' appointments over a month, and found the average to be two hours and 15 minutes. However, patients were experiencing longer waits for on the day pre-operative assessments. As a

result of patient feedback, each clinic had a dedicated nurse with specialist knowledge of that clinic who was able to undertake the preoperative checks and minimise waiting times.

- The treatment centre recorded the length of time patients were kept waiting once they arrived in the department using a colour-coded electronic traffic light system. The different traffic light colours indicated where the patient was in their journey through the hospital. The clock started from the time the patient booked into the reception desk, regardless of their appointment time (which meant it looked like a patient had waited a long time if they were booked in before their appointment time). One patient told us they were a little annoyed that they had allowed two hours for their appointment, which had only taken 20 minutes.
- Patients told us the appointments system was easy to use through the NHS Choose and Book telephone service.
- The hospital only cancelled or delayed care or treatment when absolutely necessary. When cancellations did occur the hospital recorded and investigated each individually. Patients told us cancellations were always explained to them, and they were supported to access care and treatment again as soon as possible. Cancellations were categorised as 'avoidable' (such as staff shortages) or 'unavoidable' (such as due to equipment failure), and discussed at the monthly clinical governance meeting. Between January 2015 and December 2015, there was one cancellation of an outpatient clinic due to staff sickness. Senior managers told us that when a consultant was unwell, they could nearly always find another consultant to cover the clinic, and informed patients of this.
- The hospital had specific referral criteria that every new referral had to meet. Staff told us GPs were aware of this and they had between a 3-4% rejection rate for referrals that did not meet criteria. If a referral was rejected, the GP was informed of the reasons.
- We saw that clinics usually ran on time. During our inspection all of the clinics ran to time. Staff told us if a clinic was not running to time patients were always kept informed of any disruption. However, no data was collected for the clinics other than the pre-operative clinic so we were not able to verify this.
- The diagnostic imaging service did not currently monitor 'did not attend' rates; however, staff told us it would be forming part of the governance review in the department from April 2016.
- The did not attend rates for the outpatient department showed in March 2016 there were 3,902 booked appointments, with 193 non-attendances (5%).

Meeting people's individual needs

- The hospital planned services reliably and delivered them to take account of the needs of different people. For example, the hospital was contracted to perform cataract surgery on a group of patients in Wales who had been on their local NHS hospital's waiting list for a long time. In order to accommodate these patients, staff had volunteered to put on additional Sunday theatre lists and clinics. Emersons Green NHS Treatment Centre provided a coach to collect these patients, and also provided a buffet lunch for them.
- The hospital consistently planned services and delivered and coordinated them to take account of people with complex needs. For example, a young adult with learning difficulties attended the outpatient clinic before they were due to undergo a procedure. The patient was able to bring their family with them, and was given a tour of the procedure room and clinic areas, so they knew what to expect when they came in for their test.
- Patients we spoke with were happy to raise concerns about disrespectful, discriminatory or abusive behaviours by staff, and we were told about a complaint by a patient who had not felt listened to by their consultant. A senior manager had spoken in person with the patient, and had offered to set up a meeting with the consultant to discuss the issues raised. The patient declined this, and decided to see a different consultant in the hospital and the senior manager offered to go to the first appointment with the patient.
- Support with transport was available for patients with mobility issues, such as patient transport services, which patients booked through their GP. The hospital had good disabled access; however, some of the corridors in outpatients were narrowed where there were waiting areas. Crowding in these areas was kept to a minimum by use of the pager system in the main

reception area. Staff said managing the throughput of patients and meeting their individual needs could become challenging when there were lots of clinics on, and juggled rooms to best accommodate patients.

- The outpatient and diagnostic imaging services arranged appointments so that new patients were allowed time to ask questions and have follow-up tests.
- The hospital had an electronic flagging system. However, some staff we spoke with did not know about it and were not sure how they would find out if a patient had specific needs before they attended for their appointment. All staff said the bookings or patient experience coordinator team rang and spoke to patients before their appointments, and would pick up additional needs as part of the health questionnaire they completed for every patient.
- Support for people with learning difficulties was available, but staff were unsure if there was a dedicated link nurse. Staff told us that patients with learning difficulties often attended the oral surgery clinic, and extra time in appointments was allowed for patients who needed it.
- Translation services were readily available if required, and staff could tell us how they would access them. In most cases, staff told us about the telephone translation services available, but some staff also mentioned a document translation service as well.
- Staff told us about occasions when reasonable adjustments were made so that disabled people could access and use the outpatient and diagnostic services on an equal basis to others. For example, in physiotherapy specialist equipment was available for patients to use during their treatment so they got the maximum benefits. Where possible, staff told us they ordered equipment from an equipment store in advance of the patient's appointment.
- There were several working groups in the hospital, such as the falls working group, where staff who showed an interest in the subject went to discuss and review hospital policies and procedures with a view to presenting possible improvements in meeting people's needs.

Learning from complaints and concerns

- Patients told us they knew how to make a complaint or raise concerns and they felt confident to speak up about concerns if they needed to. Two patients spoke with us during our inspection about aspects of their treatment they were not happy with. In both cases, a senior manager came and spoke with the patient and asked them what they would like to happen. In both instances the patients were satisfied with the result of the conversation with the manger, who for one of the patients had arranged a taxi to pick them up for their next appointment.
- Patients who had raised a concern were treated with compassion. For example, when a patient told the hospital they had felt their consultant had not listened to them, the senior managers offered to meet with the patient and accompany them to their next appointment with a new consultant.
- We saw that clinicians encouraged patients to make complaints or raise concerns, and patients were given written information about the complaints process, which we saw in several different languages.
- The hospital set a target to acknowledge the receipt of a complaint within three working days, and to complete the investigation within 20 working days for 95% of complaints received. Between April 2014 and March 2015, this was achieved in 96% of cases.
- We looked at a complaint and its investigation relating to the outpatients department. This was handled effectively. The complainant was updated regularly, and the outcome was explained appropriately to the individual. Lessons were recorded as a result of the complaint. These lessons were communicated to staff using a Care UK shared learning database. Action was taken to improve care as a result of the complaint, such as providing patients with clear information about referral criteria. A number of complaints had arisen because patients had not understood why their referral had been rejected.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services well-led?

Good

We rated the leadership in the outpatient and diagnostic imagine department as good. This was because:

- Staff told us they felt very well supported by their immediate line managers, departmental management team and the senior management team.
- Staff knew the vision for the hospital and strived to make sure every patient's experience was outstanding.
- Governance systems were in place. There were clear reporting structures and staff understood the risks within the departments and where improvements needed to be made.Staff were involved in governance meetings and ensured risks were minimised.
- Action plans were in place where necessary with appropriate timescales.
- The diagnostic imaging department was working towards achieving accreditation with the Imaging Service Accreditation Scheme.
- We saw that in the Friends and Family test, 98% of patients said they would be very likely or likely to recommend the departments to others.
- There was a strong culture of openness and transparency.

However:

- Some staff felt senior management styles could be overpowering at times, although this was not reflected by the majority of staff we spoke with.
- We did not see evidence of a strong emphasis on promoting the safety and wellbeing of staff, and a number of incidents reported showed staff were sometimes working through breaks.

Vision and strategy for this this core service

- The hospital had adopted a set of values which had been developed nationally. The overall vision for the hospital was to provide an outstanding experience for every patient, through patient-centred and safe care, professional and friendly staff and a service that was responsive to people's needs. Staff we spoke with were all aware of the overall vision and strategy. Most staff were aware of the role they played in helping the hospital to achieve its vision and felt proud that they lived the values in their daily work. However, staff survey results showed some staff did not feel their immediate line managers kept them informed of the future plans for their services.
- There was a clear and concise business growth plan, which focused on three key areas for growth; quality, people and business. The hospital had a clear vision for the outpatient and diagnostic imaging services. This included possible expansion into another building if hospital activity consistently outweighed the current capacity, and was developed in conjunction with the senior managers and Care UK head office.
- Senior staff were aware of the vision, and the diagnostic imaging department told us of their plans to have onsite magnetic resonance imaging (MRI) and computed tomography (CT) facilities in the future if the activity levels demanded it.
- There was a good, realistic strategy for achieving the priorities set for the outpatient and diagnostic imaging services, which involved careful monthly monitoring of activity, and an ongoing programme of engagement with GPs and other referrers.

Governance, risk management and quality measurement for this core service

- There was an effective governance framework to support the delivery of the strategy and good quality care.Staff understood their roles and what they were accountable for, which included reporting anything that impacted on patient safety and quality, including short staffing and missed meal breaks.
- We saw that within the outpatients and diagnostic imaging departments everyone was encouraged to be involved in governance. Staff told us it was all of their responsibility and not just managers. Issues were raised and discussed at local, team or multi-disciplinary team (MDT) meetings. Heads of department met monthly and took issues from local meetings for discussion. Monthly

clinical governance meetings were well attended by senior managers and heads of departments, along with patient forum representatives. Information was also cascaded down through this governance structure.

- The governance framework and management systems were regularly reviewed, and leaders of the outpatient and diagnostic imaging services demonstrated a good understanding of performance, which integrated the views of people with safety, quality, activity and financial information.
- Action was always taken to improve performance. For example, following a serious incident, the clinical governance team had improved monitoring around controlled drugs and had seen a big improvement in compliance. Regular monitoring of compliance took place on a monthly basis. There were effective arrangements in place to ensure the information used to monitor and manage quality and performance was accurate, valid, reliable, timely and relevant. For example, the hospital fed data into national monitoring programmes for referral to treatment times and NHS Friends and Family Test results.
- There was a programme of clinical and internal audit in the outpatient and diagnostic imaging services. The data from these audits was used to monitor quality and identify where action should be taken. For example, we saw the hospital had introduced a red flag dashboard, which indicated when a performance area had fallen below the hospital target, such as clinic utilisation as a result of short notice sickness. The management had taken these figures and performed a trend analysis which had shown higher incidents of sickness amongst some staff on particular days. Management were engaging with those staff affected and involving occupational health to offer additional support if needed.
- At the time of our inspection the radiology department was working towards achieving Imaging Service Accreditation Scheme (ISAS) accreditation. ISAS is a patient-focused assessment and accreditation programme. It is designed to help diagnostic imaging services make sure their patients consistently receive high quality service, delivered by competent staff working in safe environments.As the only national accreditation scheme for diagnostic imaging, it showed the department wanted to make sure the services it provided to patients were the best they could be.
- The hospital held a number of clinical governance study days every year, where activity levels were reduced to allow the maximum numbers of staff to attend training sessions.
- There were good arrangements for identifying, recording and managing risks, and risk registers were in use. When risks were identified, they were colour coded depending on the risk score. These ranged from blue, minimal risk to red, high risk. The risk scores were reviewed following any action taken. All risks had timescales and actions against them. The majority of the risks on the register were current; however, we did findseveral risks had been completely resolved, but were still on the register. These included the replacement of some dental drilling equipment, and the allocation of a private room for pharmacist and patient consultations.
- The outpatient and diagnostic imaging services had departmental hazard registers, which were a collection of all current risk assessments and their scores. There was some confusion between staff as to how risks were escalated to the hospital risk register. Some staff told us there was a threshold score of nine, above which a risk was automatically escalated, and some staff told us each risk was assessed verbally at the monthly clinical governance meeting. The risks identified on the risk registers were the same as those identified by staff as their main concerns, which included an ongoing risk around the computer systems failing.
- The hospital had external International Organisation Standardisation (ISO) 9001 accreditation through Care UK for its quality management system, and also ISO 27001 for its information services. ISO standards are designed to help organisations demonstrate they meet the needs of their patients and other stakeholders while still meeting statutory and regulatory requirements.

Leadership / culture of service

- Leaders of the outpatient and diagnostic imaging services told us they had the skills, knowledge and experience needed to do their jobs, and told us they were able to lead effectively. They understood the challenges to providing good quality care and were able

to identify the actions needed to address these challenges. The medical director had clinical time to go out and engage with staff and told us he observed processes such as the World Health Organisation (WHO) checklist, which was performed before any surgical or invasive procedure, and was available for advice.

- Leaders were always visible and approachable, and the head of nursing began every day with a walk-round of all departments and wards to see if there were any challenges ahead for that day.
- Leaders encouraged supportive relationships among staff. For example, a member of staff had raised a performance issue with another member of staff during a procedure, which was overheard and reported by another member of staff. The head of nursing spoke with the original staff member about the way they had dealt with the issue, and reminded them of correct policy, and suggested they completed a reflective piece for their revalidation.
- The culture of the outpatient and diagnostic imaging services centred on the needs and experience of patients. For example, all governance meetings began with the discussion of a patient story, and learning from that patient's experiences was discussed.
- The culture encouraged candour, openness and honesty, and staff told us they were not frightened or worried to talk with their managers if something had not gone as planned.
- We did not see evidence of a strong emphasis on promoting the safety and wellbeing of staff, and in recent governance meeting minutes a number of incidents reported in outpatients of staff working through allocated meal times were discussed. This was reflected by some staff expressing concerns at the numbers of patients booked into clinics causing some staff to work through meal breaks. The results of the staff survey also identified staff health and wellbeing as an area for improvement. Staff sickness rates in March 2016 were 3% in outpatients and 2% in diagnostic imaging, which was below the hospital target of 5%.
- The hospital was aware they could not offer the variety of work when compared to a larger NHS acute trust, and told us they were aware they could not provide a 'career for life' for some staff. However, this did not appear to be having an impact on staff retention. At the time of the inspection the nursing staffing turnover in the outpatient department was 2%, which was below the target of 15%. In diagnostic imaging staff turnover was 0%.
- Most staff told us they felt respected and valued, especially the pharmacy staff, who told us consultants and nurses regularly asked them for guidance and advice.
- We saw that staff and teams worked collaboratively. Staff told us that conflict was always resolved quickly and constructively. Action was always taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. However, some staff expressed the opinion that management was very 'top down' with a tendency to micro-manage some staff. Staff also said that despite this, engagement with the staff was very 'bottom–up', and senior managers were very accessible to all staff.

Public engagement

- The outpatient and diagnostic imaging services provided a forum for listening to the views and experiences of patients in order to shape and improve the culture and the care provided.
- The patient forum was set up to engage with, and represent the viewpoint of, patients. They were involved with a lot of internal processes and meetings, in particular the monthly clinical governance meetings. They were also asked to review and give the hospital feedback about new information leaflets and changes to letters. For example, the hospital had identified a high number of calls to the patient helpline about pain relief. Patients were currently given a pain ladder, but staff thought it was too complicated so had asked the patient forum to review the document.
- Members of the patient forum told us they felt very involved and valued, and the hospital was very open and honest with them about how they followed up on complaints and incidents. Forum members also told us they had received patient-led assessments of the care environment (PLACE) training, and had taken part in a patient engagement 'dignity' day, where they spoke with patients and obtained feedback about the hospital.
- Patient forum members told us the management was quick to act on findings and feedback from the forum. For example, visual signs had been changed to be

clearer and the hospital had bought specialist coloured crockery for patients with dementia. One member said they had never been refused an answer to any question the forum had asked.

- Outpatient surveys were used, and the results of these surveys indicated patients were very satisfied with the standard and quality of care they received at the hospital. The questions on these surveys were sufficiently open-ended to allow people to express themselves. Examples of the feedback were displayed in waiting areas we visited, with large display boards in the main reception waiting area.
- NHS Friends and Family Test data for the outpatient department in January 2016 showed 619 responses out of a 1,992 patients seen. 98% of respondents (605 patients) recommended the hospital and 2% (14 patients) did not. All of the responses were captured using an electronic tablet before the patient left the hospital. However, the hospital had set a target for a 50% response rate, and in December 2015, the outpatient department had a 22% response rate. The hospital had an action plan to help improve this.
- The hospital had recently held an open day to invite members of the public to walk round all areas of the hospital, including treatment rooms and theatres. This allowed patients, prospective patients and others with an interest in the hospital to view the facilities and ask questions.

Staff engagement

- Staff views were reflected in the planning and delivery of services and in shaping the culture. For instance the hospital had brought in an external company to look at efficiency through staff engagement, which staff told us was very interesting and made them feel involved in the hospital's future.
- When staff raised concerns, leaders recognised the importance of this and acted upon the concern. However, staff said that senior managers were not always welcoming of concern around them and felt concerns raised about senior managers were sometimes brushed aside.
- The hospital had an annual staff survey which had a 61% response rate. The survey showed staff felt proud of their work, went the extra mile for patients and would recommend the hospital to someone they knew who needed care. However, staff also said they felt they did not have opportunities for personal growth and that no change would come about as a result of the survey.

Engagement with other organisations

- Senior staff told us they had run a multi-disciplinary team training day for a team from a large NHS trust. The team had fed back that they learned a lot from the day and one summarised the experience as 'a corporate view of healthcare with a distinct overarching patient focus'. Feedback also mentioned the openness of the staff in their approach to sharing their knowledge.

Innovation, improvement and sustainability

- When the outpatient and diagnostic imaging services planned changes to the service delivery, the impact on quality and sustainability was assessed and monitored by looking at monthly activity, complaints, patient outcomes and feedback from the patient forum.
- Staff told us that financial pressures did not compromise care. However, since the changes in the service contract in November 2015 to a payment by results contract, the hospital had seen a decline in referrals and subsequent revenue. Senior medical staff told us that a survey of local GPs who referred to the hospital had been undertaken to try and identify a cause for the decline, and the hospital was trying to integrate with local referrers to establish better relationships.
- There was evidence that leaders and staff strived for continuous learning, improvement and innovation. The clinical governance lead told us the hospital always looked for new audits and benchmarking exercises to continually test the organisation. In particular, the hospital felt the Care UK housekeeping and cleaning guidance was not thorough enough, so they implemented a national housekeeping standard and presented the results of the audit to Care UK head office. Staff told us the standards had been adopted by the organisation across all of its centres and hospitals.
- Staff were always focused on continually improving quality of care. At the beginning of every governance meeting, a patient story was discussed, including any lessons learned. A patient had felt that they were being 'seen to' rather than 'cared for', and felt their privacy had not been maintained or respected. Senior managers

took learning from this and circulated it to all staff within the minutes of the meeting. Another example of patient feedback was that a patient had found it difficult to flush the toilet whilst sat on it. The hospital risk assessed this and found that in twisting to reach the flush, patients were at increased risk of falling. The hospital undertook a replacement programme of all of the cisterns on patient toilets to remove that risk.

- Quality and innovation was recognised and rewarded and staff could nominate each other for a monthly award. Emails were sent out naming each person and why they had been nominated, along with the overall winner for that month. Care UK held annual awards in London, where teams and individuals from within the whole organisation gathered to celebrate examples of exemplary care within Care UK.

Outstanding practice and areas for improvement

Outstanding practice

- The treatment centre had a policy that allowed any member of staff at any time to call a multidisciplinary team meeting if they had any concerns about any aspect of a patient's care.
- The safeguarding policies and procedures were well established and well understood by staff who gave us many examples of where the safeguarding process had been followed to help protect vulnerable adults receiving care in the hospital.
- Pharmacy staff were involved in projects to help simplify information given to patients about their medicines. This included easy read medicines sheets and a coloured coded system for the administration of eye drops post-surgery.
- The senior managers were very visible and welcomed engagement with staff and patients in both a positive and constructive manner, and frequently served as first point of contact in situations where patients were unhappy with services.
- A patient forum was set up to engage with patients and involve them in a lot of internal processes and meetings. In particular, patient forum members attended and participated in the monthly clinical governance meetings.
- Staff were very quick to offer patients apologies and the opportunity for a conversation following an incident where something had not gone as well as it should. Learning from these conversations and subsequent investigations was shared throughout the Care UK organisation.
- The hospital welcomed and was responsive to patient feedback, including feedback about patient toilets and adding specialty food items to the canteen menu.
- The physiotherapy enhanced recovery programme allowed detailed monitoring of the effectiveness of patient treatment at six weeks, with the option to refer back to the consultant if any concerns about the patient's progress arose.
- The treatment centre offered free telephone calls for all patients to landlines and mobile phones to enable patients to remain in contact with their family during their stay.
- The treatment centre was very responsive towards patients with complex needs and planned and tailored services to meet the needs on the individual patient. The treatment centre went above and beyond to optimise care, treatment and access to services for patients with learning difficulties.

Areas for improvement

Action the provider SHOULD take to improve

The provider SHOULD:

- Ensure effective communication takes place between consultants at all times and implement a clear system to flag urgent referrals.
- Consider having a contingency plan in case the diagnostic imaging computed radiography reader breaks down.
- Ensure mandatory training is completed in accordance with Care UK targets.
- Maintain records of regular tap flushing.

Outstanding practice and areas for improvement

- Ensure effective stock management is in place and that out of date items are removed from circulation.
- Implement a system to ensure diagnostic imaging staff follow up urgent referrals with GPs in all cases.
- Consider alternative parking arrangements for patients and relatives.
- Ensure the pharmacy recording, tracking and monitoring systems are fit for purpose.
- Consider enhanced training for prescribers to make sure all referral information is taken into consideration at the time of prescribing 'to take out' medication.
- Ensure the number of patients booked into a clinic is appropriate to the length and staffing of that clinic.
- Ensure staff are allowed time to take allocated meal breaks.