Queen Mary, University Of London Foundation

Wolfson Institute of Preventive Medicine

Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We did not rate this service. This is because the CQC does not apply a rating to independent laboratory services. We found:

- The service had enough laboratory staff to provide the right level of service and provided some training in key skills. The service controlled infection risk and managed cross contamination well. Staff kept good records. The service managed safety incidents and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and ensured they had access to good information. Key services were available as required to support timely care.
- Staff spoke to patients to help them understand the tests and the results and were trained to provide emotional support to patients and their families.
- The service was planned to meet the needs of local people and people could access the service when they needed it. They took account of people's physical individual needs.
- The service had a plan for the future. Staff felt valued and were focused on the needs of patients receiving care. The service engaged with the NHS trusts they supported, and all staff were committed to improving services for the future.

However:

- The service lacked sufficient management capacity and were not able to provide all their training records for staff. There were some key skills that staff were not offered training in.
- Managers did not keep accessible records of staff competencies.
- The service did not provide support for patients whose first language was not spoken English and did not make it clear to people how to give feedback.
- Leaders ran services using ineffective governance processes and poor quality management systems and were not routinely updating all documents clearly, this was exacerbated by a lack of capacity due to some management roles being unfilled for months. Staff did not have appraisals regularly and so lacked formal opportunities to request further training.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical laboratories	Inspected but not rated	We did not rate this service. This is because the CQC does not apply a rating to independent laboratory services. See the overall summary above for what we found.

Summary of findings

Contents

Summary of this inspection

Background to Wolfson Institute of Preventive Medicine

The Wolfson Institute of Preventative Medicine is an independent medical laboratory which specialises in antenatal screening tests. It is operated by the Queen Mary, University of London Foundation and had moved premises to share space with another laboratory on the university campus. The service had contracts with over 40 NHS trusts to carry out their antenatal testing and also carried out a small amount of private work, seeing an average of one patient a week on site to test.

The service had no registered manager in post at the time of inspection, however there was an application with CQC's registration team.

The service was last inspected by CQC in 2013, under our previous methodology and was not rated.

Laboratory tests funded by the NHS must be accredited against a set of standards called ISO 15189. The United Kingdom Accreditation Service (UKAS) is recognised by the government as the sole national accreditation body and once tests are accredited, there are annual surveillance activities and full re-assessment every 4th year. The service was awaiting an assessment following their relocation, but remained accredited, these aspects were not inspected.

In addition, all laboratories must participate in an external quality assurance (EQA) scheme that advises providers of their quality assurance results and how their results compare with other laboratories. This aspect of the service was not inspected.

How we carried out this inspection

This was an unannounced inspection using our comprehensive methodology.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that they provide sufficient mandatory training, including safeguarding training, to give staff the knowledge and skills to keep patients safe. (Regulation 12 (2))
- The service must ensure they have policies to guide staff to care for patients when they are on site (Regulation 12 (2))
- The service must ensure they have a process to check manufacturer expiry dates on consumables. (Regulation 12 (2))
- The service must ensure they have a systematic way of managing, storing and reviewing local policies and procedures (Regulation 17 (1)(2))
- The service must ensure they formalise contingency plans for service disruption (Regulation 17 (1)(2))

Summary of this inspection

- The service must ensure any responsibilities delegated to any other service are formalised in agreements (Regulation 17 (1)(2))
- The service must ensure there is a systematic way of managing, saving and storing staff competencies to ensure there are clear records of what individual staff members are competent to do (Regulation 17 (1)(2))
- The service must continue to try and fill vacancies to ensure effective governance processes can be managed (Regulation 17 (1)(2))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical laboratories	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated

Inspected but not rated

Medical laboratories

Safe	Inspected but not rated
Effective	Inspected but not rated
Caring	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

Are Medical laboratories safe?

Inspected but not rated

Mandatory training

The service provided some mandatory training in key skills to all staff and told us they made sure everyone completed it. However, the records were incomplete and did not include all staff.

Staff told us they completed mandatory training in line with the requirements of the university campus they were based on. However, the mandatory training did not include any clinical elements, such as basic life support, even for those members of staff who saw patients occasionally.

Managers were able to access mandatory training records to ensure staff were compliant with their training and staff received an email when their training was due to be repeated.

Following inspection, we were sent the training grid which included some staff and their mandatory training. However, the grid did not include all staff members, as some staff we had spoken with on inspection were not included. In addition to this the grid did not identify which modules were required for which staff members.

Safeguarding

Staff were not regularly trained to recognise potential signs of abuse and they were not aware of any supporting policies telling them who to report concerns to.

The service occasionally saw patients for testing on site. There was no regular safeguarding training for staff who saw patients. Staff we spoke with, who had clinical roles, had completed safeguarding training in previous roles, but had not completed training whilst working for this service.

The service did not have a policy to support staff to report patient safeguarding concerns. Staff were not able to identify a safeguarding lead for the service and told us if they were worried about the safety of a patient they would contact the hospital the patient was registered with. Following the inspection, we were sent the safeguarding policy for the university the service was a part of. However, this policy specifically stated it did not cover safeguarding concerns from the community and was solely for concerns raised by or about staff members. We were also sent another policy from the university; however, this was out of date and was due for review in 2016, this policy also only covered safeguarding of staff and university students and not patients.

Inspected but not rated

Medical laboratories

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect themselves and others from infection and prevent cross contamination of specimens. They kept equipment and the premises visibly clean.

The laboratory was located on the first floor of a building. We inspected the service during COVID-19 pandemic restrictions and saw that access was controlled in ways to help reduce the risk of viral transmission. Staff wore personal protective equipment (PPE) and, where possible, were socially distanced from each other.

The service had completed a COVID-19 risk assessment and had identified and implemented control mechanisms to protect staff from the virus. Working protocols to reduce the risk of cross contamination we reviewed were up to date with guidance. We also observed staff following these protocols.

The service was clean and had clear guidelines for general housekeeping to identify precise duties and the frequency they needed to be carried out. This guideline also outlined the personal protective equipment (PPE) that staff needed to wear while completing cleaning tasks. In addition to the general housekeeping guidelines the service had processes for disinfection following spillages or breakages.

Environment and equipment

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

The laboratory had sufficient space for the equipment that was required to process tests and for staff to use it. They had more analysis machines then they needed to ensure if one needed maintenance they could process the tests they needed to in a timely manner.

The analysis machines were regularly checked for accuracy on a daily, weekly and monthly basis.

The environment, including air-conditioning, fire protection and water services, fixtures and fittings were controlled and maintained by the larger laboratory the service sat within. However, there were no formal service level agreements or contracts that laid out expectations to keep the service's equipment and machines safe to use.

Entry to the laboratory was restricted by security locks, which we saw being operated by staff as they moved through the building. Office and administrative areas were separated from laboratory and storage rooms.

The clinic room was a shared space with other services. The service had boxes in the room to store equipment. We found equipment in the boxes that was out of manufacturers use by dates and requested it be removed and replaced.

The service had refrigerators to store samples that required temperature control which were regularly checked

The service signed up and complied with reporting requirements for applicable external quality assurance groups. External quality assurance groups are national groups that monitor average results and ensure quality of the results across all laboratories.

Clinical or laboratory waste was handled, stored and removed in a safe way. Staff segregated and handled laboratory and general waste in line with national guidance. There were arrangements to manage the disposal of waste and clinical specimens.

Inspected but not rated

Medical laboratories

Assessing and responding to patient risk

Staff assessed risks to patients for each test carried out on site. Staff prioritised positive results and had mechanisms in place to ensure results were clearly communicated.

The service saw a small number of private patients on site, to take blood samples. Before patients were seen for blood to be taken they were screened by a qualified midwife, who explained the purpose of the testing and what the results were able to tell them.

Positive results were shared with NHS trusts separately to negative results, this process was introduced to reduce the risk of positive results being missed. Administrative staff followed up with hospitals to ensure they had received and actioned any positive results.

The service had recently moved premises and had negotiated with the security team at their new base that any samples that came in out of hours were put into storage correctly to stop them degrading.

Laboratory staffing

The service had enough laboratory staff with the right qualifications, skills, training and experience to provide the right level of service. However, they were struggling to fill laboratory manager and quality manager roles to support staff working in the laboratory.

Staff working in the laboratory processing tests were all laboratory technicians who completed a competency book when they started, to ensure their competence.

The service was in the process of trying to hire a new laboratory manager, following the previous one leaving in July 2021. They told us they had mitigations in place to support staff while the role was vacant. The job had been advertised previously, but they had not recruited, the service was looking at other ways of filling the role.

Staffing included two midwives to support with interpretation of the results and communication with patients about results. The midwives also took blood samples from private patients when they came in for testing and explained results to patients when they were available.

Senior clinical staffing

The service had a medically qualified consultant to provide clinical advice.

The service manager was not registered with the Health and Care Professions Council (HCPC). However, they had years of experience in the specialist field and had a scientific background to support their practical knowledge. Normally this would prevent UKAS accreditation, however, there were exceptions for highly specialised laboratories, such as this service.

The service had a clinical director who was an obstetrician by clinical background. They provided clinical oversight of the service and were available for staff to ask questions of, should they arise.

Records

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

Inspected but not rated

Medical laboratories

There were systems to ensure patient's samples and records were kept separate. All staff had access to an electronic records system that they could update, ensuring information was available on the system in a timely manner.

Administrative staff were trained to ensure expected sample lists from hospitals were inputted into the computer records ready for specimens to be logged into the service. They knew the required minimum standards for information were and rejected any referrals that did not meet them.

Administrative staff also prepared the results ready to be sent back to the referring hospital. Different hospitals had different preferences for how this was done, and staff were aware of them.

Medicines

The service stored and used medical reagents safely and had enough stock to last a few weeks, should there be any service line disruption.

Incidents

The service had incident reporting systems and staff knew how to report incidents. Managers reviewed incidents. Managers ensured that actions from safety alerts were implemented and monitored.

The service had two incident reporting systems. One was to report incidents that had originated at the service, the other was a spreadsheet to log when samples arrived from NHS trusts without the correct documentation. This allowed the service to understand whether delays in processing and reporting on samples derived from their processes or other services. Staff knew which incidents needed reporting in which system.

Laboratory staff were clear about which samples needed to be rejected, if they were at risk of cross contamination and where this needed to be reported.

We were told there had been no serious incidents in the past 12 months.

When incidents were reported to the service, by NHS trusts they also investigated these. We were told an example of a courier who was picking up samples refusing to follow COVID precautions and being rude to NHS staff. This was reported to the service who spoke to their third-party couriers who addressed the problem and the service had not received any similar reports since this time.

We saw governance meeting minutes that indicated where there had been incidents, managers shared findings with staff and lessons had been learnt.

Are Medical laboratories effective?

Inspected but not rated

Evidence-based care and treatment

The service followed national guidance when presenting and interpreting results. Managers made sure staff followed quality control procedures.

Inspected but not rated

Medical laboratories

The service was aware of the key assurance indicators set out by the Royal College of Pathologists. Key assurance indicators measure not only whether something is being done but also whether the task is being completed to the expected quality. The lab was compliant with most key assurance indicators but was not able to provide documentation to evidence this for all indicators.

The service manager participated in meetings with other screening laboratories around the country to share best practices and learning.

The service regularly attended meetings with the national screening programme to ensure they were compliant with, and had input into, the national guidelines.

Patient outcomes

Staff monitored the effectiveness of their service. They used the findings to make improvements and achieved good outcomes. The service used external quality assurance schemes (EQA) to monitor and check their results.

The laboratory staff explained the regular programme of checks to ensure results were accurate. In addition to this the service reported results into the applicable EQA programmes. The service showed us their recent submissions to both EQA programmes, and the results were mostly within expected limits. The one result that had not fallen within expected limits had been retested and investigated. The service had discussed their results with the national programme, and it was agreed this was most likely down to the sample, and not the laboratories processes.

The results of the EQA audits were shared and discussed at the monthly staff meetings. Laboratory staff we spoke with were aware of the results of the most recent audits and any actions that were required.

The service was accredited by the United Kingdom Accreditation Service (UKAS) under the ISO151819 accreditation. They were expecting another accreditation inspection by UKAS in the near future as they had moved premises in the summer and were preparing for that inspection.

The service retained samples for one year after testing, this meant any anomalous results or concerning results could be retested for, without having to draw blood from the patient a second time.

Competent staff

The service made sure staff were competent for their roles, however, were not able to provide evidence of this for all staff. Managers did not regularly appraise staff's work performance but told us they held informal meetings with staff regularly.

Laboratory staff were experienced, qualified and had the right skills and knowledge.

The service manager had appropriate education and experience but was not formally registered with HCPC, as normally expected by UKAS accreditation. The service manager was supported by a clinical director who was a registered doctor and two registered midwives.

All staff were provided training for their individual roles. However, the service was not able to provide evidence of this for all members of staff. We asked to see one laboratory staff members competencies and they were unable to find them, therefore there was no way to check that member of staff was competent to carry out the tasks they were completing.

Inspected but not rated

Medical laboratories

Staff told us they were supposed to have annual appraisals. However, due to the pandemic and gaps in staffing, this had not been possible for many members of staff in the past year and many were out of date.

Multidisciplinary working

Staff worked with other providers' teams to benefit patients. They supported each other to provide a good service.

We observed good working relationships between laboratory staff, administrative staff and the midwives. There was information sharing between the teams and we were told open discussions about potentially anomalous results were common.

We were also told the service had good working relationship with the NHS trusts they had contracts with. NHS staff were able to ask the laboratory to speak with patients to clarify results and the service collated and shared information about when samples had been mislabelled or packaged incorrectly with the NHS to reduce the number of patients who needed retesting.

Seven-day services

Key services were available to support timely care.

Due to the nature of the work the laboratory carried out there was no need for the service to work seven days a week. They were able to reach turnaround time targets working Monday to Friday.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were not trained to support patients to make informed decisions about their care and treatment. They did not receive training to know how to support children and patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The service saw a few private patients on site and these patients were managed by the two registered midwives. The midwives did not receive training from the service to identify patients who were lacking the capacity to consent to treatment. They also did not receive training to identify any patients under the age of 18 who may not be able to consent for testing.

The midwives described to us what they would do if they were concerned about a patient's ability to consent to treatment. However, there was no policy or guidance to support them to make decisions about patients' capacity to consent to testing and no policy or guidance to support them to care for patients deemed not to have capacity. The service did have a policy to identify capacity in young adults aged between 16 and 18 but staff were not aware of this and the policy was not dated or version controlled.

Are Medical laboratories caring?

Inspected but not rated

Compassionate care

We did not observe any patient care during our inspection.

Inspected but not rated

Medical laboratories

Emotional support

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

We were told patients who attended on site could have a chaperone for testing if they requested one.

The midwives who had contact with patients had undertaken training in having difficult conversations and breaking bad news to patients. Therefore, they had the skills to manage conversations about positive results in a way that was kind but clear to patients.

The midwives told us they never broke bad news to a private patient in a letter. They always had a conversation with them and gave them opportunities to ask questions and then followed this up with written confirmation of the results.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and laboratory results.

Staff had a conversation with patients and their partners before they attended for a test to explain what the results could, and could not, tell them. This ensured patients and their loved ones were prepared for the results and any limitations of these.

Are Medical laboratories responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

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

The service had maintained the screening programme throughout the COVID-19 pandemic to ensure patients had access he w p to testing and results.

The service supported over 40 NHS trusts and sent out an annual user survey to obtain opinions on the service and to make service delivery improvements. In addition to this, if patients were not able to access screening services through the NHS the service offered a privately funded service. In the year before the inspection the service saw 58 patients privately.

Meeting people's individual needs

The service was accessible and they coordinated with other services.

The clinic room was accessible for patients with limited mobility and had enough space to accommodate a wheelchair if this was needed.

The service did not have access to translation services, either verbal or British sign language. Written information was only provided in English.

Inspected but not rated

Medical laboratories

The service routinely had contact with the hospitals the private patients were having their maternity care at. Patients consented for results to be shared and this enabled joined up care if the patient had complex needs.

Access and flow

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

For NHS contracted work the service provided results in a timely manner and met their expected turnaround times. The service had different contracts with different hospitals, for some hospitals they sent the letters to patients, for others they provided the results electronically to the hospital, who informed the patients.

There were times when samples needed priority testing and laboratory staff we spoke with were able to describe how they knew which samples these were and confirmed they were always given priority.

The service stored samples for one year following testing. This meant any anomalous results could be repeated without having to draw blood from the patient for a second time. This allowed retesting to be completed quickly and without any additional hospital visits for the patient.

Learning from complaints and concerns

People could give feedback and raise concerns, however this was not made clear by the service. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients were able to raise concerns with the service, but this was not made clear to them. We were not shown any leaflets with the complaints process outlined, nor any letters where a complaints procedure is described. We were told patients could raise complaints or concerns in person, or on the telephone and these would be escalated to the service manager. Staff who directly spoke to, or saw patients, were clear about how to acknowledge complaints.

The service manager described a process for managing complaints, but staff were not aware of any formal policy to manage complaints. Following the inspection, we were sent a complaints procedure, this was written recently but, was not version controlled and had no date for review. The procedure did outline the responsibilities of the service.

Are Medical laboratories well-led?

Inspected but not rated

Leadership

Leaders had the knowledge to support decision making, however lacked understanding and awareness of wider governance and regulatory requirements. They understood some of the priorities and issues the service faced, however due to staffing levels lacked time to manage them all. They were visible and approachable in the service for staff.

Service leaders were knowledgeable in the area the service specialised in, however they had not identified some of the concerns we highlighted and were not working to address them all at the time of the inspection. This was exacerbated by the service lacking people in some key leadership roles, meaning existing leaders were stretched and were managing day to day with little capacity for forward planning.

Staff told us the service manager was approachable and they felt able to ask questions or for support and that it was clear to them who they needed to approach with queries or concerns.

Vision and Strategy

The service had a business case to plan for the future they were in the process of rewriting a new business case, following the recent organisational changes.

The service had a business case that laid out plans for ongoing and planned research, education, finances and potential risks. We were told the service was aware this was no longer all relevant, as the service had moved premises and there had been wider organisational changes that made some of the plan outdated.

The service was writing a new five-year plan, which was yet to be completed. We were told the five-year plan had a renewed focus on the research aims of the service and that discussions had started with local trusts about data sharing and ethics approvals.

Culture

Staff felt respected, supported and valued. They were focussed on the needs of patients and referring clinicians.

Staff we spoke with told us they were able to ask questions and raise concerns openly and were happy to work for the service.

We were told there was limited scope for staff to progress in the organisation due to the size of the service. However, staff were able to request flexible working arrangements to allow them to undertake training. Staff told us they were able to request funding for training courses to develop their knowledge or skills, although acknowledged this would not lead to job role progression.

We were told staff went above and beyond their contractual obligations to NHS providers to support patients to understand their results. If there were patients who had complex questions about their results NHS clinicians were able to ask staff to speak with them to provide more detail, this was solely to benefit the patient and was not contractually required.

Governance

The service lacked effective governance processes for all aspects of the service including those with partner organisations. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had recently been part of an organisational restructure and staff were still not clear where they sat within the wider organisation. However, staff were clear about who they needed to escalate concerns or queries to locally.

Locally the service was informally split into administration teams, the midwife care team and the laboratory team, these all reported into the service manager, due to the vacancies reported in ‘safe’. The service manager reported into the clinical director, who was also responsible for other organisations. The clinical director reported to the wider university structure.

The service did not operate effective document review mechanisms. We noted their quality manual was not well version controlled and was a combination of two versions, with some inaccuracies. Following inspection, we were sent an updated version of this document, which had been corrected. We asked the service manager about the system where documents were stored and how they were highlighted as needing a review. We were told the service did not have a document management system or a systematic way of identifying documents that needed a review or updating.

The service manager told us due to the lack of senior staffing described in 'safe' they were unable to manage policies and protocols well and were behind on this, this meant some policies and protocols were not within their review time frames.

The service had systems and processes for ensuring all samples were accurately logged in and traced through the service. This system was in line with national guidance.

Staff were encouraged to attend monthly staff meetings to hear key messages and to have a formal opportunity to raise concerns or ideas. The minutes of these meetings were shared with any staff who were not able to attend.

The service did not have all required service level agreements in place with other organisations that managed parts of their processes for them. This meant there was no formal agreements that the other organisations were responsible for these tasks and they could be missed.

Management of risk, issues and performance

Leaders and teams used systems to monitor performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They did not have plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service maintained a local risk register which linked with the wider corporate risk register when risks needed to be escalated. The local risk register did not have clear dates for risks to be reviewed but did identify control measures and identified people who were responsible for the risk. However, for five of the 24 identified risks to the service the laboratory manager was identified as the responsible person, this role had remained vacant since July 2021. Therefore, it was unclear who was managing these risks.

The service did not have a formal plan to manage if events seriously disrupted their service provision, or if key senior staff members were not available. We were told that the service manager knew what to do, and where there was capacity in the system to maintain their testing services. However, there were no documented agreements with other organisations to facilitate this which meant if the service manager was not available there was nothing to guide other staff members.

The service had systems and processes to monitor their performance and to ensure their test results were accurate. As described in 'effective' these were also monitored by external quality assurance programmes that the service reported into at regular intervals.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications may not have always been consistently submitted to external organisations as required.

Staff could find the data they needed, in easily accessible secure formats, to understand performance, make decisions and improvements.

There were systems to ensure the information used to monitor, manage and report on quality and performance were accurate, valid, reliable and timely. There was a monthly staff meeting where information about the accuracy of testing was shared and any changes to practice were discussed with all staff.

The analysis and reporting systems were secure and all systems were password protected. Results were shared with the referring NHS trusts predominantly over email and there were ongoing discussions evidenced with multiple trusts about the most efficient way to manage this.

All staff were expected to complete information governance training and confidentiality training. Following inspection, we were sent the training records. These showed that only 1 of the 7 applicable staff had completed this training. However, as described in 'safe', the list of staff on the training matrix was not complete, therefore this list did not show how many staff had completed, or were missing, this training.

Engagement

Leaders and staff actively and openly engaged with staff and NHS organisations they had contracts with to plan and manage services.

The service sent all the NHS trusts they worked with an annual survey about their satisfaction with the service they received. The most recent survey was mostly positive with NHS trusts saying they were very satisfied or satisfied with the service they received. Where NHS trusts had made comments for improvement there were actions identified to make future improvements.

In addition to the survey sent to NHS trusts the service also had regular meetings with hospitals if requested. After inspection we were sent the agendas for meetings with NHS trusts and they showed detailed lengthy discussions about service delivery and possible future improvements.

The service surveyed staff to ensure they were making their working life as easy as possible. All staff were surveyed to understand their IT requirements and if they needed any improvements. There was another survey for staff involved in research to understand their views of the service. The service manager told us staff were always welcome to bring up concerns or ideas at any time, and this was encouraged in the monthly staff meetings.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The service was part of a larger university organisation and research and publications were still regularly part of their work. They had a good understanding of research methodologies and with so many NHS trust links they were well placed to understand the changing needs of patients.

The service was looking at ways to use the information they received from blood tests to give hospitals the most information about their patients, without needing further testing. One potential area the service was looking into was assessing the risk levels of patients experiencing pre-eclampsia during pregnancy.

Inspected but not rated

Medical laboratories

The service was working through contractual arrangements and ethics committees with local NHS trusts to begin a new piece of in-depth work to compare tests results with actual patient outcomes. This required the sharing of patient notes and had not yet been formally agreed.