St Mary's NHS Treatment Centre

Quality Report

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Date of inspection visit: 29 and 30 September, and 8 October 2015
Date of publication: 09/02/2016

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

St Mary's NHS Treatment Centre opened in December 2005, and provides services to people living in Portsmouth, Fareham, Gosport and South East Hampshire. NHS treatment centres are private-sector owned, but contracted to treat NHS patients free at the point of use. Care UK Clinical Services Ltd, the largest independent provider of NHS services in England, took over St Mary's in 2008.

The treatment centre provides urgent and emergency (minor injuries and minor illness) care to the local population in a modern, purpose-built minor injuries unit (MIU), staffed by specialist practitioners. It also provides day case elective surgery to NHS patients within the following specialities: orthopaedics, general surgery, ophthalmology and endoscopy. (We have reported on endoscopy in the outpatients and diagnostic imaging report).

Admission to the treatment centre for surgery follows strict referral criteria for people aged 16 years and over who require routine -urgent surgery. There is an outpatient department within this building for routine pre and post-operative appointments.

The treatment centre has a day case ward with 15 bed spaces. There are three operating theatres, plus an endoscopy suite operating Monday to Friday.

We carried out a comprehensive announced inspection of St Mary's NHS Treatment Centre on 29 and 30 September 2015, and an unannounced inspection on 8 October 2015.

We inspected the following three core services:

- urgent and emergency service /minor injuries unit
- surgery
- outpatients and diagnostic imaging.

The overall rating for this service was 'Good'.

The services at this treatment centre were safe, effective, caring, responsive and well led. The centre took into account individual patient needs and preferences when designing the delivery of well-planned services to the local population. There were sufficient staff, and robust processes, ensuring the appropriate provision of timely and compassionate care.

Our key findings were as follows.

Are services safe?

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

- The centre protected patients from the risk of abuse and avoidable harm. There were clear, open and transparent processes for reporting and learning from incidents. Staff reported incidents and managers shared learning locally and within the wider organisation.
- The departments were visibly clean and staff followed infection prevention and control practices. Post-operative infection rates were lower (better than) the national hospital average.
- Patients were risk assessed to ensure they were suitable for treatment at the centre and staff monitored them appropriately during their stay. Children under two years could attend the minor injuries unit, but the nurse practitioner would then seek advice from a senior doctor at the local trust.
- An audit programme set by Care UK reviewed clinical practice against local policies. This enabled benchmarking both locally and within the Care UK group. Audits completed in July 2015 showed compliance with policies regarding perioperative hypothermia, recording of fluid balance, completion of the five steps to safety checklists, VTE assessments and training for safeguarding children and adults was between 98% and 100%.
- The centre appropriately maintained and tested equipment.

Summary of findings

- Medicines were stored securely and handled correctly.
- Staffing levels were sufficient to meet the needs of patients and there was good access to medical support at all times. Managers calculated nurse-staffing levels around the planned workload using an adapted recognised safer staffing tool. Staff said it was rare managers did not keep to planned staffing levels. Medical staff were available at all times when patients were present in the surgical department.
- The centre held patients' records in paper format and electronically, and these were always available before a patient was seen. All medical records stayed on site and staff archived them after six months.
- Staff undertook appropriate mandatory training for their role, and managers supported them to keep this up-to-date. There were also training and developmental opportunities for all staff.
- All staff we spoke with knew where to access policies, procedures and guidance to follow in the event of a major incident. Senior staff were also aware of their individual responsibilities in the event of a serious or untoward incident on the premises.

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.

- Minor injuries unit services were available seven days a week, with surgery taking place five days a week. In the outpatients department, the centre held clinics mainly in the week, with some on Saturdays. By working in multidisciplinary team and 'one-stop' clinics, the treatment centre reduced the number of appointments patients needed.
- Staff delivered evidence-based care in line with nationally agreed policies and practice, for example, guidance from the National Institute for Health and Care Excellence (NICE).
- Staff had attended training relating to the Mental Capacity Act best practice guidelines and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with were aware of the DoLS policies and procedures.
- Staff had regular appraisals and supervision, and were encouraged and supported to take part in training and development.
- We spoke with patients after their visit to the unit and they told us clinical staff had sought their consent before any examination, care or treatment.
- The treatment centre was performing in line with other organisations providing the same surgery. Patient outcomes were monitored through national quality monitoring schemes, corporate audits and locally developed audits.
- Staff met patients' pain needs and reviewed them appropriately during a procedure or investigation. In the minor injuries unit, staff assessed patients for their levels of pain during the triage process. However, at the inspection we raised concerns that the unit did not use any pain score tools. When we returned to the unit for an unannounced inspection, we found they had introduced pain scores for both children and adults which were being used effectively.

Are services caring?

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

- Staff treated patients with courtesy and respect, and patients were fully involved in decisions about their care.
- In all departments, patients and relatives commented positively about the care provided by all the staff, including those who were non-clinical.
- Staff on the main reception and the outpatient department reception were highly praised by patients and relatives for their welcoming attitude, discretion and attention to detail. Reception desks were a sufficient distance away from waiting areas so patients could speak to reception staff in confidence. There were signs behind reception desks giving the names of the receptionists. Receptionists in both the outpatient department and day surgery unit stated that they believed their role was to look after patients and observe them while in their area.
- Patients told us staff always treated them with discretion and ensured their privacy.

Summary of findings

Are services responsive?

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

- In MIU, the centre planned and delivered services in a way that met the needs of the local population. Services reflected the importance of flexibility, choice and continuity of care.
- Staff took into account the needs of different people, for example, patients living with dementia, learning, or other disability conditions. Not all staff had received training in such conditions, but there was a process in place to ensure staff saw these patients as quickly as possible.
- Surgical services were responsive to the needs of local people. Patients were able to influence the choice of date for their surgery during outpatient consultations.
- Patient admissions for surgery were staggered throughout the day so they did not have to wait a long time after their admission.
- The treatment centre met national waiting times and patients had surgery within 18 weeks of referral.
- St Mary's planned outpatient services well, and the facilities were appropriate to support the running of the different specialist clinics.
- Before their first attendance, the centre sent patients appropriate information about, for example, the consultant or clinic they were to see, the length of appointment time, any treatment they might have at the first appointment.
- Waiting times for a first appointment were three weeks or less for all specialties. The national referral to treatment time (18 week target) was met for all specialities.
- The centre reminded patients about their appointment the day before, through a computer-generated text or a personal telephone message. Patients generally had additional tests performed on the day of their appointment.
- Complaints were responded to in line with Care UK's complaints policy. The registered manager had responsibility for overseeing the management of complaints, with the individual department leads carrying out complaint investigations that were relevant to their area of work.
- The centre took comments from patients seriously, and this led to planned changes for waiting areas. The commissioners had supported a review of increased opening hours because of longer waits in the local hospital.

Are services well-led?

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.

- Senior managers were highly visible across the hospital. Staff described knowing them on first name terms, and said they were approachable at all times.
- Staff spoke highly about their departmental managers, about the support they provided to them and to patients. All staff said managers supported them to report concerns. Their managers would then act on them. They said their managers regularly updated them on issues that affected the unit and the whole hospital.
- Staff in MIU knew and understood the vision, values and strategic goals of their service and of their treatment centre. The information used in reporting, performance management and delivering the quality of care was accurate, valid and timely. There was a structured governance programme for the treatment centre, which included governance meetings locally at the treatment centre and regionally with other Care UK treatment centres.
- Governance processes at department level, treatment centre level and corporate level allowed for monitoring of the service and learning from incidents, complaints and results of audits across surgical services.
- Records from these governance meetings showed St Mary's followed a structured process for monitoring outcomes, risks, effectiveness, staffing (including sickness rates), vacancies, and compliance with mandatory training.

Summary of findings

- Information on people's experience was reported and reviewed alongside other performance data. This enabled the translation of strategy into effective performance management.
- In outpatients and endoscopy, staff had a clear ambition for the service and were aware of the vision for the organisation. The unit displayed its vision and strategy plans on notice boards in the staff room. The department supported staff who wanted to be innovative. Patients could give feedback about their experiences and the centre used this to improve the service.
- We observed a newly formed patient forum. A group of patients came together to discuss the treatment centre and its services to the community.

We saw several areas of outstanding practice including:

- In endoscopy, the latest Joint Advisory Group [JAG] accreditation report gave overall feedback that the treatment centre was an 'excellent' facility. JAG praised the leadership, environment, high-quality service and well-trained workforce. The JAG report recommended considering completing the JAG accreditation for training.
- In outpatients, patients were able to talk in person with the appointment schedulers to arrange their next appointments before leaving the treatment centre. The schedulers were able to provide appointment options from which the patient selected a choice relevant to their life and preferences. This provided a very personalised service.

However, there were also areas where the provider needs to make improvements.

The provider **should ensure**:

- That appropriate arrangements for monitoring and auditing the management and use of controlled drugs are in place.
- That antibiotic liquid medicines given include an expiry date once reconstituted.
- That appropriate actions are taken when it is identified that medicines have been stored outside of their recommended temperature range
- Health visitors are informed of children attending MIU.
- All relevant staff working in the MIU receive training in dementia and learning disability.
- Written literature is available in different formats, such as large print or braille, and languages other than English, and provide directions on how to access patient information.
- All staff are aware of the risk and hazard register records that relate to their ward/department areas.
- All areas have their own risk register or a dedicated section within the central risk register.
- A review of the walk-in service for x-ray patients is undertaken to improve waiting times and flow.
- The Diagnostic target is added to the risk register.
- Consider screening lead coats, used within fluoroscopy, annually in line with best practice guidelines.

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
Urgent and emergency services	Good	The Minor Injury Unit was clean and there were good infection prevention and control practices to reduce the risk of infection. Staff risked assessed patients to make sure only those that were suitable received treatment at the unit. Staff were aware of processes to follow in the event of an emergency. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately through flexible working patterns and bank staff. The centre did not use agency staff. People's care and treatment was planned and delivered in line with current evidence-based guidance. The unit monitored the service by undertaking audits to ensure consistency of practice. Audits undertaken showed patients were seen in a timely manner. Patients were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. Feedback from patients who used the service, and those who were close to them, were positive about how they had been treated by staff. Patient's privacy and confidentiality was respected at all times. Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services. Care and treatment was coordinated with other services and other providers. Complaints were handled appropriately and there was an effective process for learning from complaints. Staff in all areas knew and understood the priorities for the service. Governance arrangements at department level, treatment centre level and corporate were appropriate to monitor quality and safety and action was taken on areas identified for improvement, for example through risks or complaints. Staff were positive about the leadership of the service and identified a positive culture.
Surgery	Good	There were systems in place to keep patients safe from harm. Staff reported incidents and shared learning

Summary of findings

locally and across the organisation. Learning from incidents resulted in changes to practices. Wards and departments were visibly clean and there were good infection prevention and control practices. Patients were risk assessed to ensure only those suitable received treatment at the centre. Managers calculated nurse staffing levels around the planned workload using an adapted recognised safer staffing tool. Staff said it was rare managers did not keep to the planned staffing levels. Medical staff were available at all times when patients were present in the surgical department.

There were training and development opportunities for all staff, including attendance at regional and national conferences.

Staff were caring and compassionate, and treated patients with dignity and respect. Patients told us they felt informed about their treatment and had been involved in decisions about their care, which included choices about the date of surgery or other procedures. There was an interpreter service available for patients whose first language was not English. However, there was no literature available in other languages or other formats, such as large print. There was no information for patients letting them know interpreting services were available.

The provider planned services to meet patient needs including staggered admission times on the day of surgery to reduce the time patients spent in the department. There was an effective process for managing and learning from complaints.

There were governance, risk management and quality measurement systems at departmental, treatment centre and corporate level, which allowed for monitoring of the service and learning from incidents, complaints and results of audits across surgical services. Staff were positive about the leadership of the service.

Outpatients and diagnostic imaging

Good

There were systems in place to keep patients safe from harm. Staff reported incidents and shared learning locally and across the organisation. Learning from incidents resulted in changes to practices. Wards and departments were visibly clean and there were good infection prevention and control practices. Patients were risk assessed to ensure only those suitable received treatment at the centre. Managers calculated

Summary of findings

nurse staffing levels around the planned workload using an adapted recognised safer staffing tool. Staff said it was rare managers did not keep to the planned staffing levels. Medical staff were available at all times when patients were present in the surgical department.

There were training and development opportunities for all staff, including attendance at regional and national conferences.

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There was an interpreter service available for patients whose first language was not English. However, there was no literature available in other languages or other formats, such as large print. There was no information for patients letting them know interpreting services were available.

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Summary of findings

Contents

Good

St Mary's NHS Treatment Centre

Services we looked at

Urgent and emergency services; Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to St Mary's NHS Treatment Centre

St Mary's NHS Treatment Centre is a unit situated in Portsmouth, close to the site of St Mary's Hospital. It opened in December 2005, and provides services to people living in Portsmouth, Fareham, Gosport and South East Hampshire. Independent NHS treatment centres are private-sector owned treatment centres contracted to treat NHS patients free at the point of use. Care UK Clinical Services Ltd, the largest independent provider of NHS services in England took over St Mary's In 2008.

The treatment centre provides urgent and emergency (minor injuries and minor illness) care to the local population within a modern purpose-built minor injuries unit, staffed by specialist practitioners. It also provides day case elective surgery to NHS patients within the following specialties: orthopaedics, general surgery, ophthalmology and endoscopy. (We have reported on endoscopy in the outpatients and diagnostic imaging report). Admission to the treatment centre for surgery follows strict referral criteria for people aged 16 years and over who required routine non-urgent surgery. There is an outpatient department in the building for routine pre and post-operative appointments.

The treatment centre has a day case ward with 15 bed spaces. There are three operating theatres and an endoscopy suite operating Monday to Friday.

We carried out a comprehensive announced inspection of St Mary's NHS Treatment Centre on 29 and 30 September 2015, and an unannounced inspection on 8 October 2015.

We inspected the following three core services:

- urgent and emergency service/minor injuries unit
- surgery
- outpatients and diagnostic imaging.

The registered manager has been in post since 2011.

Our inspection team

Our inspection team was led by:

Inspection manager: Moira Black, Care Quality Commission.

The team included CQC inspectors and five specialist advisers, including a consultant surgeon, a senior nurse, a consultant nurse, a radiographer and a governance specialist.

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 spoke to the local clinical commissioning group. We invited patients to contact CQC with their feedback.

We visited the treatment centre to undertake an announced inspection on 29 and 30 September 2015 and undertook an unannounced inspection on 8 October 2015.

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 MIU, surgical, endoscopy and outpatient areas.

Summary of this inspection

We spoke with day case patients and people attending the outpatient clinics. We looked at comments made by patients when completing the hospital satisfaction survey and reviewed complaints that had been raised with the hospital.

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

We did not inspect the core areas of medicine, critical care, maternity, care of children and young people, or end-of-life care, as St Mary's did not provide these services.

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

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experience of the quality of the care they received at St Mary's NHS Treatment Centre.

Information about St Mary's NHS Treatment Centre

- In 2008, Care UK acquired Mercury Health and staff were transferred to the new provider... Care UK successfully retendered for the contract in 2011 and were awarded a three-year contract with a further extension for one year. The contract was recently re-tendered and a new five-year contract starts on 1 January 2016. The new contract will also include the Havant Diagnostics service, which was previously a separate contract.
- The clinical staff included 37 whole time equivalent nurses plus 59 other staff including operating department staff and healthcare support workers. There were four doctors directly employed and a further 20 working under rules or privileges.
- Inpatient activity/overnight inpatients – 0
- Visits to theatre - 6,895
- Outpatient activity: 4,849
- Never Events reported during the reporting period **April 2014-March 2015**: NIL
- Serious Injury: eight
- Clinical Incidents: 119
- Incidence of hospital acquired venous thromboembolism (VTE): NIL
- Infection Control: No reported incidence of Clostridium difficile (C. diff) or Methicillin resistant staphylococcus (MRSA)
- Incidence of unexpected mortality during the reporting period **April 2014-March 2015:** NIL
- Rate of unplanned readmissions within 29 days of discharge during the reporting period: Nil, they do not have inpatient beds.
- Number of unplanned transfers during the reporting period: nine cases of unplanned transfer of an inpatient to other hospitals in the reporting period (**April 2014-March 2015)**
- NHS Friends and Family Test (FFT): This showed consistently high scores but within a very small sample of fewer than 30% of patients treated at the centre.
- Completed admitted pathways – the centre met the national target (90%) in all months between April 2014 and March 2015.
- Completed non-admitted pathways – the centre met the national target (95%) in all months between April 2014 and March 2015, with the exception August 2014.
- Incomplete pathways – the centre met the national target (92%) in all months between April 2014 to February, but was not met in March 2105
- Complaints received – 54. The centre monitored and managed all of these within the formalised Care UK Complaints Policy timescale – 20 working days.
- Turnover - Low staff turnover for all staff groups for all hospital-wide staff groups. High level of vacancy for endoscopy staff.
- Sickness rate - A mixed level of sickness across the staff groups. Higher in theatre staff over the period July and August 2014.

Summary of this inspection

- Staff stability – low levels of staff stability working within theatres.
- Low staff turnover for all staff groups except for registered nurses in inpatient departments: moderate (30%) in 2013 and high (44%) in 2014.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

1. We will rate effectiveness where we have sufficient, robust information that answer the KLOEs and reflect the prompts.

Good

Urgent and emergency services

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

Information about the service

The Minor Injury Unit (MIU) is open from 7.30am to 10pm, seven days a week. The last patient is booked at 9.30pm. The unit has two entrances: one for children and one for adults. Patients see a receptionist who escalates any concerns to an appropriate clinician. The clinician then decides on the level of urgency.

The unit also has a radiology department that is open during the same opening hours as the MIU. There is one designated eye room and one plaster room.

There are two designated paediatric rooms and one adolescent room. The adult side of the centre has 11 rooms. The number of patients attending the MIU in 2014 was 45,118.

During this inspection, we visited the MIU. We spoke with eight patients and 11 staff in a wide variety of roles. This included medical staff, senior nurse practitioners, nurse practitioners, paramedic practitioners, managers, health care assistants, and administrative staff. We looked at the patient environment and observed patient care in all areas. We looked at 11 patients' records. Before and during our inspection we reviewed the provider's performance and quality information.

Summary of findings

The Minor Injury Unit was clean and there were good infection prevention and control practices to reduce the risk of infection. Staff risked assessed patients to make sure only those that were suitable received treatment at the unit. Staff were aware of processes to follow in the event of an emergency.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately through flexible working patterns and bank staff. The centre did not use agency staff.

People's care and treatment was planned and delivered in line with current evidence-based guidance. The unit monitored the service by undertaking audits to ensure consistency of practice. Audits undertaken showed patients were seen in a timely manner.

Patients were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. Feedback from patients who used the service, and those who were close to them, were positive about how they had been treated by staff. Patient's privacy and confidentiality was respected at all times.

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services. Care and treatment was coordinated with other services and other providers.

Good

Urgent and emergency services

Complaints were handled appropriately and there was an effective process for learning from complaints.

Staff in all areas knew and understood the priorities for the service. Governance arrangements at department level, treatment centre level and corporate were appropriate to monitor quality and safety and action was taken on areas identified for improvement, for example through risks or complaints. Staff were positive about the leadership of the service and identified a positive culture.

Are urgent and emergency services safe?

Good

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

We rated 'safe' as good.

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they were fully supported when they did so.

The Minor Injury Unit was clean and there were good infection prevention and control practices to reduce the risk of infection. Staff risked assessed patients to make sure only those that were suitable received treatment at the unit. Staff were aware of processes to follow in the event of an emergency.

Medicines were labelled appropriately. However, we found antibiotic liquid medicines where the labelling did not include an expiry date once reconstituted.

Staff followed appropriate procedures to safeguard vulnerable adults and children and young people. However, health visitors did not currently follow up children who visited the unit and this was being planned.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately through flexible working patterns and bank staff. The MIU did not use any agency staff.

Incidents

- Staff members told us they had access to the NHS national safety alerts and resources on the intranet. Staff understood how to report incidents and how managers investigated them. They gave us examples of how managers shared learning from incidents in team meetings. They monitored and reviewed these incidents and gave staff a clear understanding of patient safety. One senior clinical staff member told us how managers shared incidents at individual supervision sessions. They told us it became a focus of their own professional and personal development.

- Staff told us there were regular 'debrief sessions' after an incident being reported. They found these sessions helpful.
- As part of their induction, staff had received training on the incident reporting system used by the treatment centre. When staff reported an incident, they received an email confirming managers would investigate. They received a follow-up call from the head of the service and the hospital director on the reported incident. They also received feedback once the investigation was complete, and managers shared the outcome widely with staff as part of their monthly meetings.

Cleanliness, infection control and hygiene

- The MIU had been purpose built. It was clean and well maintained. All the areas we visited had a cleaning schedule. These schedules were completed and checked daily by the nursing staff. The cleaning staff told us they had access to equipment and training necessary for undertaking cleaning. Cleaning staff who carried cleaning duties received appropriate training and supervision. Staff were informed of any potential outbreaks of any infectious disease, or illness from the nearby acute hospital. We saw notices advising patients with diarrhoea and vomiting to inform staff at the point of triage, which was carried out shortly after they arrived. The unit had single-room facilities that could be used to assess and treat potentially infectious patients. This helped to reduce the risk of cross-contamination and the spread of infections.
- There were sufficient hand washing stations for staff during clinical activity and for patients and visitors to the unit. There were clear reminders and guidance about handwashing techniques. We observed staff encouraging patients to wash their hands before and after their consultation.
- Medical equipment was cleaned regularly after use. This was evidenced by 'I am clean stickers'.
- There were various audits undertaken on hand hygiene including handwashing and cleanliness audits. The results of the latest handwashing audit showed more than 98% compliance to the standard. The cleanliness audit showed 100% compliance to the standard set by the Centre.

Environment and equipment

- Staff told us they had sufficient supplies and appropriate equipment they required to treat patients.
- Inspection of equipment including checking maintenance dates, and checking of the emergency equipment showed that these had been regularly undertaken. We checked five pieces of equipment and they were all safe to be used and had been recently checked.

Medicines

- Medicines were stored safely including flammables and those requiring extra controls (controlled drugs). All treatment rooms were secure requiring swipe access, and medicine cupboards were locked. The keys to access the controlled drugs storage were kept within the secure treatment room and within a safe. There was no signature seen within the control drug register to indicate that an independent check of the controlled drugs had taken place. This meant there was a likelihood of control drugs being given to inappropriate patients or control drugs missing. The treatment centre was aware of this anomaly and had addressed this concern by putting a system to ensure checks were done every time a control drug was given. This procedure was in place at the unannounced inspection of the service.
- There were good processes in place to obtain medicines, and monthly checks by an appropriate member of staff (pharmacy assistant) were in place to ensure medicines remained safe to use. This member of staff communicated any supply issues to the rest of the team in order to put any necessary contingency plans in place. There was a regular review of stock holdings to make sure appropriate medicines and stock levels were maintained. The medicines management committee approved any new medicine for use.
- Medicines were disposed of safely and the appropriate records kept.
- Medicine recalls and alerts were dealt with appropriately. For example, a record of recent alerts was available for all staff to access within the treatment room.
- All medicines were within date and items supplied for individuals to take home were labelled on how to be used, with the exception of antibiotic liquid medicines where the labelling did not include an expiry date once

reconstituted. This meant patients could receive medicines that had expired making them ineffective in the treatment of the condition. There were clear records indicating which medicines had been issued to patients.

- Medicines requiring cold storage were kept in the refrigerator, which was monitored. Records were made of medicine refrigerator and room temperatures on a daily basis. However, we inspected the records of one year and found the monitoring of the refrigerator temperature to be within acceptable standards except two weeks in August and September 2015 when the maximum reading of the refrigerator was out of range and data was not recorded as to what action had been taken. This meant medicines that require refrigeration within specific temperature range to maintain their effectiveness could be rendered ineffective because the temperature was higher than required.
- Reference material for staff to use with regards to the use of medicines such as the British National Formulary (BNF) was available either in hard copies or online.
- Patient Group Directions (PGDs) were in place to allow some types of registered health professionals to administer or supply medicines in specific circumstances without them having to see a prescriber. The PGDs were all authorised appropriately for use within Care UK, they were in date and there was a record of staff who could use them.
- FP10 prescriptions were stored and managed safely and a log of serial numbers was kept to ensure appropriate use. This was necessary as it ensured prescriptions were only issued to patients who required the medicines.
- There was piped medical gas available in most of the unit and in the one room where it was not present there were cylinders for use. These were safely stored so they could not be tampered with and in date.
- Emergency medicines were available on the resuscitation trolley. There were four resuscitation trolleys in the building. The resuscitation trolley in MIU contained three bags of medicines; one was for the treatment of anaphylaxis. Anaphylaxis is an allergic reaction to an antigen (eg a bee sting) to which the body has become hypersensitive. The second bag contained a potassium chloride 15% ampoule, which should not be available outside of specified critical care areas as defined in the NPSA Patient Safety Alert 23 July 2002. The risk to patients was it could be used accidentally causing harm to patients. This was highlighted to staff who took appropriate actions immediately.
- The resuscitation trolleys were checked daily to make sure the trolley seal was intact and thoroughly checked once a month for the contents. There were extra supplies of emergency medicines held within the treatment room should a resuscitation trolley be replenished.
- Staff confirmed there was a record of staff who were non-medical prescribers (NMPs).

Records

- There was good record keeping at the treatment centre. We saw evidence of managers undertaking monthly audits of random samples of patient records. Areas of concerns were identified and the findings were shared with staff.
- We inspected 11 computerised patient's treatment records and found accurate records of information.
- There had been detailed assessment of the patient's condition or injury and other relevant factors such as current medicine and medical history. Copies of records were provided to the patient's GP or to children's services for follow up if required.
- There was an audit of record keeping in April 2015. Following this audit, staff were provided with additional training and time to ensure accurate recording of information.

Safeguarding

- There were clear policies for dealing with any suspected abuse of vulnerable adults or children. Staff told us they had attended training about safeguarding of vulnerable adults and children. The clinical lead and the manager of the MIU told us that all staff were trained to an appropriate level of safeguarding awareness. All staff had received level 2 children safeguarding training.
- The child protection register was checked for all Hampshire cases. However, if the patient came to the centre as part of their holiday or visit to the sea front, the child protection register was not checked routinely. There was a safeguarding children's questionnaire in

place. This was completed by the parent on registration of their child and gave clinical staff clues to identify any potential safeguarding concerns that they could explore when attending to the child.
- All attendances were notified to the family doctor for appropriate follow up. Follow up by health visitors for children had not yet been put in place. There were on-going discussions with the Clinical Commissioning Groups on this.

Mandatory training

- The training database showed that all mandatory training had been completed as required. There were monitoring systems in place and line managers identified to staff where there were gaps in the recording of training. Staff were then given protected time to complete this training.

Assessing and responding to patient risk

- The MIU had an appropriate room and resuscitation equipment in place to manage seriously ill patients until an ambulance arrived.
- A receptionist saw all patients during the opening hours on arrival and, if they were obviously in need of urgent care or treatment, the receptionist alerted nursing staff immediately. Receptionists had received training on the conditions that needed to be seen by the emergency nurse practitioner. Receptionists reported urgent conditions such as chest pain, back pain, shortness of breath, excessive bleeding and head injury with loss of consciousness and vomiting to the emergency nurse.
- All patients were risk assessed by nursing staff at the point of "see and treat". A triage nurse saw patients within 10 minutes of arrival. We observed the triage nurse take a brief medical history, identify the patient's condition or injury and the priority of treatment required. Patients were seen based on the urgency of their condition.
- At the inspection, we raised concerns that the minor injury unit did not have in place any early warning score system. Such a system can help assess patient's severity of illness and thus enable a timely intervention. However, at the unannounced visit, we found the unit had introduced early warning score system and staff had received training in its use. Staff told us this had further improved the quality of the service as they were able to identify any potential patients who required interventions earlier to improve their care.
- Staff told us that any patient who had severe illness would be rapidly transferred to a local emergency department by ambulance. The unit had a protocol in place that described categories of patients who would need to be transferred to a local emergency department.

Medical staffing

- There was a medical director who was the person responsible for the MIU. He was located off site. He was contactable daily, if required. The unit had appointed a weekly emergency department consultant who attended weekly review clinic. The unit also employed an orthopaedic consultant who attended twice a week. Both the consultants provided support to nursing staff and reported directly to the medical director.

Nursing staffing

- The unit employed seven full time equivalent (FTE) senior nurse practitioners, five FTE nurse practitioners and four FTE paramedic practitioners. In total there were 16 trained staff. It also employed one FTE senior health care assistant, one health care pharmacy assistant and four FTE health care assistants. It also employed six FTE reception staff.
- The nursing establishment was based on the Care UK model for the unit and was sufficient to see the current number of patients. The daily minimum staffing levels were as follows. On weekends and on Mondays between the hours of 7.30am and 10am, the unit employed three nurse practitioners, two health care assistants and one reception staff. Between the hours 10am and 6pm, the unit employed five nurse practitioners, two health care assistants and two reception staff. Between 6pm and 10pm, the unit employed four nurse practitioners, two health care assistants and two reception staff. From Tuesday to Friday, between the hours 7.30am and 10am, the unit employed three nurse practitioners, one health care assistant and one reception staff. Between the hours 10am and 10pm, the unit employed four nurse practitioners, two health care assistants and two reception staff. There was always a senior nurse practitioner on duty.
- This level of staffing took account of the requirement of the service and patient safety. Staff told us they were consulted on the agreed staffing levels.
- Nursing staff had completed an emergency nurse practitioner course.

Good

Urgent and emergency services

- The MIU did not use any agency staff and staff shortages were either filled through flexible working or bank staff. Staff told us that there was on going recruitment for nursing staff through open days.
- The unit had introduced paediatric nurses. Children were seen more quickly and this reduced waiting times,
- Both patients and staff commented the unit was well staffed.

Major incident awareness and training

- There were clear protocols to support major incidents or events and staff were aware of their role. There were flow charts in place and staff were aware of what actions. For example, they knew that if the local hospital was on a "black alert" and could not take any more patients through their emergency department, the ambulances diverted suitable patients to the minor injury unit.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

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.

We rated 'effective' as good.

People's care and treatment was planned and delivered in line with current evidence-based guidance. The unit monitored the service by undertaking audits to ensure consistency of practice. Audits undertaken showed patients were seen in a timely manner.

Staff were qualified and have the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training is put in place to meet these learning needs. Staff were supported to maintain and further develop their professional skills and experience by attending study days and conferences.

Staff were supported in their role through appraisals and supervision. Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal.

Staff were encouraged and supported to participate in training and development to enable them to deliver good quality care. Staff had an understanding of the Mental Capacity Act 2005, and its application to their area of work.

Evidence-based care and treatment

- Staff routinely used up to date online guidance to ensure the care and treatment provided was according to best practice. All policies and procedures seen made reference to the National Institute for Health and Care Excellence (NICE) guidelines. Staff had access to these policies.
- The unit had a list of exclusion criteria and if any patients attended with ailments such as severe trauma or stroke then staff would assess them but also call for an ambulance to convey them to a local A&E department for appropriate treatment.
- Staff followed agreed patient group directions when prescribing medicines for specific conditions and types of patient.
- The unit undertook clinical audit of treatment protocols. For example, clinical audits on radiology reporting were undertaken to ensure the unit followed the guidelines set.
- There were regular audits on to ensure medicines were prescribed according to the protocols set by the unit. The results of these audits were discussed at staff meetings and followed up as part of clinical supervision.
- There were regular audits undertaken and changes made as a result. For example, because of the audit of recording of notes, staff were provided with additional training and time to ensure accurate recording of information.
- Daily x-ray checks were conducted by the nurse in charge to monitor any discrepancies with x-rays that had been undertaken for patients who visited the unit. This confirmed patients received appropriate treatment. Where there was a discrepancy, it was actioned immediately.

Pain relief

- Staff assessed patients for their levels of pain during the triage process. However, at the inspection we raised

concerns that the unit did not use any pain score tools. When we returned to the unit for an unannounced inspection, we found they had introduced pain scores for both children and adults. At the unannounced inspection, we spoke to three parents and two adult patients and they all told us they had been offered effective pain relief. Medicines for pain relief were administered, as required, under patient group directions (PGDs).

Patient outcomes

- Patient outcomes were assessed through patient satisfaction questionnaires. The results showed that patients were highly satisfied with the services provided. For example, the latest results in August 2015 showed 98% of patients who visited the unit were satisfied with the service provided. However, we found the results of these questionnaires were not visibly displayed in the MIU.
- Patients we spoke with during the inspection were very happy with the waiting time for treatment in the MIU. We saw audits of waiting times that showed the unit met the local target of the waiting time of all patients to be seen within two hours.
- The unit measured a number of clinical outcomes. For example, it monitored the percentage of patients discharged with appropriate treatment and advice. It also monitored the percentage of patients that the unit had to refer to the acute trust for specialist treatment.

Competent staff

- The staff recruited to the MIU were experienced and well qualified staff who previously worked in accident and emergency departments or as paramedics. The staff were able to work independently in providing diagnosis and treatment for injuries and emergency conditions.
- All nurses had completed a minor injury and minor illness care qualification.
- All healthcare assistants had been trained to National Vocational Qualification (NVQ) level 3 or the new Qualifications and Credit framework (QCF) equivalent.
- Paramedics worked to the PGD. The unit also had nurse prescribers. This meant that staff were fully qualified to diagnose and treat the conditions or injuries of patients.
- The appraisal rate during 2014 and 2015 was 100%. Data inspected showed all staff working in the MIU received supervision sessions on a monthly basis. Staff confirmed they received appraisals and supervision sessions.
- There was always at last one advanced life support trained staff on duty at each shift. This ensured patients who need any advanced life support intervention would have at least one senior nurse adequately trained in this.
- The MIU offered staff a two-day in-house radiology course to ensure practitioners remained up to date.

Multidisciplinary working

- The minor injury unit collaborated with nearby services such as the emergency department at a local hospital to ensure appropriate treatment for patients. For example, when the local emergency department had long waits, patients were given the option for having their ailment treated by the minor injury unit. We were shown examples of when the unit was kept open for longer to ensure patients from the nearby emergency department could attend.
- There were close links with a local walk in centre and patients were sometimes referred from that unit.
- Staff told us they worked collaboratively with other professionals. For example, they had good relationships with other health professional teams on the wards at a nearby hospital. They told us other health and social services could always be contacted for advice.

Access to information

- We checked 10 set of notes and found all had been fully completed. Electronic discharge summaries were sent out to GPs either on the same day or, at the latest, by the morning of the next day.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they had attended training about their responsibilities relating to the Mental Capacity Act best practice guidelines and deprivation of liberty safeguards. Staff we spoke with were aware of the Deprivation of Liberty Safeguards policies and procedures.
- We spoke with patients after their visit to the unit and they told us that clinical staff had sought their consent prior to examination.

Good

Urgent and emergency services

Are urgent and emergency services caring?

Good

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

We rated 'caring' as good.

Patients were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive. Feedback from patients who used the service, and those who were close to them, were positive about how they had been treated by staff. Patient's privacy and confidentiality was respected at all times.

Patients told us they their care and treatment had been explained in a way they could understand and that they felt well supported. Information and advice was available to promote and support patients to manage their own care.

Compassionate care

- Patients told us staff were kind and treated them with respect.
- Patients spoke highly about the care, treatment and support they received. Relatives and patients told us that they relied upon services provided locally because the nearest acute hospital was considered busy and a long way to travel.
- Patients told us that staff spent a considerable time in assessing their needs and providing treatment and advice. We spoke to patients after they were seen and treated and they told us they were given time to explain their injury and background information. We saw that staff patient interactions were positive and effective. Staff used appropriate communication skills and showed a caring and compassionate attitude.
- Staff treated patients with respect. Staff checked rooms before entering to ensure other staff were not treating patients.
- Treatment was provided in private rooms to maintain the privacy and dignity of patients. Staff had diversity training and could demonstrate how to maintain patients' privacy and dignity.

Patient understanding and involvement

- Staff spent time asking about their pain and other concerns. People were asked if they were happy to have their treatment.
- We spoke with five patients after their treatment and they all told us they were given full explanation before their treatment. Patients also told us they were asked before they left if they had any concerns about their care.
- Children were spoken with in a kind way appropriate to their age and with the parent fully involved.

Emotional support

- Staff were attentive and empathetic treating patients. We saw a nurse had sufficient time to allow the patient to discuss fears and anxieties around their treatment. In this way, the nurse gained the trust of the patient that helped facilitate treatment.

Promotion of self-care

- Patients were given discharge leaflets and/or advice on health promotion topics, such as smoking cessation. All care was consented to and aftercare agreed to verbally and documented. Where follow-up appointments were required to monitor treatment and progress, these had been made and clearly documented.
- Patients were given detailed guidance to enable them to manage their follow up effectively.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Good

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

Services are planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services. Care and treatment was coordinated with other services and other providers.

Patients were seen in a timely manner. The needs of different people were taken into account when planning

and delivering services. For example, patients living with dementia or who had a learning disability were seen quickly, although not all staff had received training of these conditions.

There were clear guidelines on the types of injuries that could be treated by the minor injury service.

Patients were able to access translation services as and when they required it. However, the centre did not have literature in other formats or in languages other than English. This meant that patients who had difficulty reading or those whose first language was not English might have difficulties fully accessing information.

Complaints were handled appropriately and there was an effective process for learning from complaints.

Service planning and delivery to meet the needs of local people

- The service was commissioned by local clinical commissioning groups. The unit had a service specification that provided types of injuries and circumstances that could be treated by the minor injury service (MIU). This included, for example, bruises, minor dislocation recent eye injury and others.
- The local urgent care board reviewed plans for the service when there were pressure on emergency departments at local hospitals. The commissioners had provided additional funding to keep the service open longer and recently (February 2015) the commissioners supported a review of increased opening hours because of longer waits in the local NHS hospitals.
- The staffing arrangements at the MIU had been changed to meet the variable demand for the service. For example, staffing numbers were increased during major local events such as festivals.

Meeting the needs of individuals

- Patients living with dementia or who had a learning disability were seen as a priority by the emergency nurse practitioners. However, not all staff had received training in dementia or learning disability.
- The service was responsive to the needs of local population. Staff were aware of local Eastern European workers in the areas served and explained that they used a combination of telephone translations, internet based translation programmes and family members to enable effective communication with people whose first language was not English.
- Leaflets were available in multiple languages if requested. However, there was no information on how to request such leaflets in different languages. This meant people who spoke languages other than English would not know that leaflets were available in other languages.
- A translation service was available if required and staff knew how to access it. There were no signs in other languages that would suggest to patients who did not speak English that they could access an interpreter

Access and flow

- The unit monitored patient waiting times and it met its own target of 95% of patients to be seen by a triage nurses within 10 minutes of arrival. The triage nurses assessed the needs of the patient before they were subsequently treated for their condition.
- Patients who attended the minor injury unit were supported in their discharge home by clear instructions to the patient and family but also through notification to any relevant community services and the patient's GP.
- Links with health visitors had not yet been established. There were on-going discussions with the local clinical commissioning group on how to take this forward. At the time of the inspection there were no plans in place on how links with the health visitors would be established.

Learning from complaints and concerns

- Patient information on how to make a complaint were clearly visible throughout the reception and waiting areas. The MIU monitored complaints and we found there were very few complaints about the MIU service. Comments from patients were taken seriously and this had led to changes being planned for waiting areas.

Good

Urgent and emergency services

Are urgent and emergency services well-led?

Good

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.

We rated well led as Good.

Staff in all areas knew and understood the priorities for the service. Governance arrangements at department level, treatment centre level and corporate were appropriate to monitor quality and safety and action was taken on areas identified for improvement, for example through risks or complaints. Staff were positive about the leadership of the service and identified a positive culture.

Information on people's experience was reported and reviewed alongside other performance data, and patients were involved in service improvement.

Staff told us they were encouraged to improve services. Innovations like the carer's survey had a positive impact on the service.

Vision and strategy for this this core service

- Staff told us they were aware of the treatment centre values and the key focus of providing high quality of care. The MIU had identified three key priorities for the service: continuously improve waiting times, recruit and retain staff through teaching and training and a flat governance structure that empowers staff. These three priorities were known to staff.
- Staff were aware of the importance of their service to the local community and were proud that they provided a service that met local needs. The staff were aware of the service that was to be provided as commissioned for the local population. Staff were also aware of the context of the service in relation to GPs, out of hours services, and local NHS emergency department provision. Staff felt proud that their work was, for example, reducing waiting times in the local A&E department and the unit was meeting local people's needs.

Governance, risk management and quality measurement for this core service

- Governance arrangements at department level, treatment centre level and corporate level allowed for monitoring of the service and learning from incidents, complaints and results of audits across surgical services.
- Monthly clinical governance meetings took place and staff were invited to this to share their ideas to improve the service.
- All staff followed protocols to care for patients within their competencies. For example, only nurses who had completed a nurse prescribing training programme could prescribe medicines. There were regular audit of protocols for treatment.
- The MIUs provided quality and performance information to senior managers and for governance oversight of the service. There were changes to practice as a result. For example, the waiting time to see a clinician was monitored, and staffing arrangements had been changed to meet the variable demand for the service.
- The MIU had a risk register in place. This was reviewed by the unit on a monthly basis. For example, recently (August 2015), the unit identified the recruitment of appropriate staff as a risk. As a result, the unit was planning open days to recruit more staff. This was due to take place in November 2015.

Leadership / culture of service

- There was a medical director who was the person responsible for the MIU. He was contactable daily, if required. The unit had appointed a weekly emergency department consultant and an orthopaedic consultant who attended twice a week. Both were employed by Care UK. The administrative and clinical lead of the service welcomed these medical inputs as it ensured the service was safe. For example, the consultants provided clinical staff with feedback on the patients who were seen at the unit. Staff told us these were learning opportunities for them.
- Staff were positive about the leadership of the service. All staff we spoke with told us there was good leadership of the MIU by the administrative and clinical head of the department. Staff told us they were aware of clinical need and focussed on service improvement and ensuring the service was responsive to local communities. They had introduced a head of the clinical service who was accountable for the clinical care for the

department. This meant there was always a "clinician in charge" of the service at any given point in time. This resulted in a service where the leadership team had empowered the staff to carry out changes in their department. For example, the MIU felt empowered to create a bespoke training for clinical staff. Staff we spoke with welcomed this initiative.

- There were strong managerial links to other community nursing services, which meant effective and efficient co-ordination of services for patients. Staff told us the NHS Treatment Centre Hospital Director was visible and accessible, and the MIU leadership had the same culture of visibility and accessibility. Staff we spoke with described the culture of the service as "patient focussed and patient led."
- The administrative and clinical lead supported the staff well by encouraging appropriate professional education and training, and ensuring roles and responsibilities were clear. For example, the reception staff and health care assistants told us they were very happy and proud to work in the MIUs. They said they knew who to discuss any issues with.

Public and staff engagement

- The MIU engaged with the local young people's charity and they were involved in the design of the paediatric treatment rooms. When the refurbishment had been complete, the young people were invited to see the new rooms.
- There was a patient forum to support and highlight areas for service improvement. This had led, for example, to improvements to the waiting area
- To ensure relatives had support when they went home, the MIU piloted a carer's survey.

The purpose of the carer's survey was to understand any improvements required to the Centre from the perspective of a relative accompanying a patient. As a result of the survey, the unit introduced a follow-up call after a few days to patients who had visited the unit with a relative. The call was to ask about their general well-being after a visit.

- The director of the centre sent out a monthly newsletter to all staff. This newsletter highlighted the achievements and challenges of the treatment centre.
- There are staff recognition awards for which other staff nominate their colleagues. This has had a positive impact on the culture of the service.

Innovation, improvement and sustainability

- A new contract was being agreed to keep the MIU open for longer. The MIU was also going to introduce a virtual fracture clinic to allow more work to be done at the unit.
- This meant patients would not need to travel to a local A&E unit for minor injuries that could treated by the MIU.
- The unit had introduced paediatric nurses. Children were seen more quickly and this reduced waiting times,
- The MIU introduced an appointment system to improve the patient experience for follow up visits and patients were seen very quickly.
- There was a comprehensive counselling service provided to staff. This led to improvement of morale and reduced absenteeism.

Good

Surgery

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

Information about the service

St Mary's NHS Treatment Centre provides elective surgery to NHS patients within the following specialities: orthopaedics, general surgery, ophthalmology (eye surgery) and endoscopy. (Endoscopy has been reported on in the Outpatients and Diagnostic Imaging report.) Admission to the treatment centre for surgery follows strict referral criteria for people aged 16 years and over who require routine non-urgent surgery.

The treatment centre has a day case ward with 15 bed spaces. The treatment centre does not provide a service for patients who require overnight admission, only day case surgery. There are three operating theatres, none of which has laminar airflow air filtration systems.

There is a recovery area for patients to be cared for immediately post anaesthetic. The centre has a Central Sterile Services Department (CSSD) where surgical instruments are sterilised.

Between April 2014 and March 2015, there were 6,895 patient visits to the theatre.

During our inspection, we visited the day case ward, recovery area, theatres and CSSD. We spoke with 10 patients, and 14 staff in a wide variety of roles. This included managers, health care assistants, registered nurses, medical staff, theatre personnel, operating department assistants and administrative staff. We looked at the patient environment and observed patient care in all areas. We looked at seven patients' records. Before and during our inspection we reviewed the provider's performance and quality information.

Summary of findings

There were systems in place to keep patients safe from harm. Staff reported incidents and shared learning locally and across the organisation. Learning from incidents resulted in changes to practices. Wards and departments were visibly clean and there were good infection prevention and control practices followed. Patients were risk assessed to ensure only those suitable received treatment at the centre. Nurse staffing levels were calculated around the planned workload using an adapted recognised safer staffing tool. Staff said it was rare that the planned staffing levels were not adhered to. Medical staff were available at all times when patients were present in the surgical department.

There were training and developmental opportunities for all staff, including attendance at regional and national conferences.

Staff were caring and compassionate and treated patients with dignity and respect. Patients told us they felt informed about their treatment and had been involved in decisions about their care, which included choices about date of surgery or other procedures. There was an interpreter service available for patients whose first language was not English. However, there was no literature available in other languages or other formats, such as large print.

The provider planned services to meet patient needs including staggered admission times on the day of surgery to reduce time patients spent in the department. There was an effective process for managing and learning from complaints.

Good

Surgery

There were governance, risk management and quality measurement systems at departmental, treatment centre and corporate level, which allowed for monitoring of the service and learning from incidents, complaints and results of audits across surgical services. Staff were positive about the leadership of the service.

Are surgery services safe?

Good

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

We rated 'safe' as good.

Patients in surgery were protected from the risk of abuse and avoidable harm. There were clear open and transparent processes for reporting and learning from incidents. Staff shared learning from incidents locally and across the other treatment centres of the organisation.

Wards and departments were visibly clean and there were good infection prevention and control practices to reduce the risk of infection. Patients were risk assessed to make sure only those that were suitable received treatment at the centre. Patient risks were reviewed and patients were appropriately monitored during their stay. Staff were aware of processes to follow in the event of an emergency.

Equipment was well maintained and tested in line with manufacturer's guidance. Medicines were stored and handled correctly.

Staffing levels were calculated using an adapted recognised safer staffing tool and were sufficient to meet the needs of patients safely. Medical staff was available at all times when patients were being treated in the department. This included anaesthetists who were available to respond to medical emergencies.

Incidents

- Staff reported incidents on an electronic reporting system. Staff confirmed they had received training about how to input incidents and the type of incidents that needed to be reported and who the incidents were reported to. Staff confirmed they received feedback about incidents they had reported.
- Root cause analysis (RCA's) of incidents was completed. This included investigation, into the event, identification of contributory factors to the incident, lessons learnt, and detail of apologies to patients if the incident related to a patient's experience. RCA reports evidenced the full investigation and any recommendations made in

response to the incident were shared with all departments in the treatment centre, with senior management for Care UK and with the local Clinical Commissioning Groups.

- The hospital had reported 119 Clinical Incidents within the reporting period (April 2014 to March 2015). There had been an overall increasing rate of reported incidents in the same period. However, there was no breakdown of these figures to detail how many related to surgical services. The provider reported eight serious incidents in the reporting period (April 2014 to March 2015). Three of these related to surgical services. Full RCA were competed, that included recommended action to reduce the risk of similar occurrences. There were no themes to incidents, which meant there was no indication that similar incidents were reoccurring.
- Incidents were reviewed at monthly clinical governance meetings. Records form these meetings showed learning and changes to practices were made in response to incidents. Learning from incidents at other Care UK locations was shared.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient's safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. Staff knew about of the Duty of Candour legislation. All understood the legalisation involved being open and honest with patients, although not all staff fully understood the processes involved.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The Treatment Centre collected data on the incidence of pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (VTE). The provider reported on this data at clinical governance meetings. The centre used these results to encourage staff to continue following procedures and good practice guidelines to prevent reoccurrence of these incidents.
- Results were displayed so patients and visitors were informed of the result's.

Cleanliness, infection control and hygiene

- All areas were visibly clean.
- Antibacterial hand disinfectant gel was available at the entrance to all ward areas and throughout the treatment centre.
- Staff adhered to the 'bare below the elbows' policy when providing care and treatment. Disposable aprons and gloves were readily available. Staff used them when delivering care and treatment to patients to reduce the risk of cross infection.
- Surgical equipment was sterilised on site in the central sterile services department (CSSD). Endoscopy staff managed the washing and sterilization of endoscopy equipment in a safe and effective manner.
- Infection prevention and control audits of the environment on the ward area, CSSD and theatres were carried out on a rolling programme over the year. Copies of the audits we looked at showed there were no concerns with infection control practices, which included hand hygiene and aseptic techniques and the environment in those areas. The most recent audits completed in October 2015 showed 100% compliance with handwashing for the ward area. For the theatre complex in October 2015, the audit identified one step of handwashing was missed by one member of staff. The audit detailed the action taken to educate the member of staff and all other staff to reduce the risk of handwashing not being fully completed.
- The treatment centre employed their own cleaning staff. Cleaning staff were allocated to a specific unit/area of the centre and cleaning schedules were displayed throughout the service.
- Results published in August 2015 from Patient-Led Assessments of the Care Environment (PLACE) resulted in scores of 98% for cleanliness of the environment and 95% for the condition, appearance and maintenance of the environment, for the hospital. The scores were not broken down into individual services. These results were lower than the centre's results for the previous year, but for cleanliness remained within the normal range for both NHS and Independent Healthcare services and for condition, appearance and maintenance of the environment were above the England average for both NHS and Independent healthcare services.
- At the pre-operative assessment stage, following certain criteria staff identified patients that required screening for methicillin-resistant Staphylococcus aureus (MRSA),

a type of bacterial infection that is resistant to a number of widely used antibiotics. Patients identified as having MRSA, had their surgery postponed whilst treatment to eradicate MRSA was completed.
- There was an Infection Prevention and Control lead Nurse (IPCN) for the centre that supported infection control link staff from each department.
- Between April 2014 and March 2015 there had been two postoperative surgical site infections.
- There had been no MRSA or Clostridium Difficile infections since the Treatment Centre opened in 2008.

Environment and equipment

- Resuscitation trolleys were kept on the ward and in theatres. We saw staff checked these daily.
- Equipment was visibly clean. Items we checked were labelled with last service date and review date. They also had an asset number for ease of tracking if it required servicing or maintenance. Portable appliance testing was undertaken.
- Each department had a health and safety representative who completed audits of the environment on a monthly basis to ensure the environment and equipment was safe for patients and staff.
- There were four operating theatres in the theatre suite one of which was mainly utilised for endoscopy procedures. None of the theatres had preparation rooms (rooms where equipment for the next procedure would be prepared). The equipment required for each procedure was prepared in the operating theatre. This is not uncommon practice in operating theatres and posed no risk to patients undergoing surgery.
- There was a well-equipped recovery room to care for patients in the immediate post-operative period before returning to the ward areas.
- There were processes followed for monitoring and maintaining theatre equipment. Staff reported all equipment needed for theatre lists was available and in working order.
- Hoists were available to assist with the mobilisation of patients who had difficulties with mobilising independently. However, staff said, due to the nature of patients admitted to the treatment centre, hoists were rarely required. Servicing of hoists was in line with intervals specified by the manufacturer. Staff were trained annually on how to use the hoists safely.
- Call bells were accessible in all areas so patients could call for assistance.

Medicines

- Staff reported all medicine errors, such as prescribing errors or not signing for administration of medicines, via the electronic incident reporting system to the company pharmacist. The pharmacist monitored all pharmacy related incidents and took appropriate action to reduce the risk of similar incidents happening.
- There was piped medical gas on the wards and in theatres. There were medical gases in cylinders for transfer of patients through the treatment centre.
- Medicines were securely locked in cupboards. Medicines that required storage below a certain temperature were stored in a locked refrigerator, specifically for that purpose. We saw the minimum and maximum temperatures were checked daily and when required readings were outside the safe parameters, were reported promptly.
- Staff confirmed that, before administering medicines, they had completed training and had their competency assessed to administer medicines.
- Medicines were appropriately packaged and labelled to be given to patients to take home after their procedure or surgery. Records provided an audit trail for all medicines given to patients to take home post procedure or surgery or those given to patients to be taken as preparation for procedures prior to admission.
- There were relevant Patient Group Directives (PGDs) in date for medicines that nursing staff gave to patients without a formal prescription. A PGD provides a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor. A PGD is used in situations that offer an advantage to patient care, without compromising patient safety.

Records

- There were pathway packs for all day case procedures pre- procedure assessments, risk assessments, preoperative checklists and records from the surgical procedure. There was also recovery room documentation, observation records, discharge check list and discharge review. Staff said the record packs were easy and logical to use. The ordering of the records meant that information about a patient's care and treatment could be located promptly.

- Staff also had to enter some of the same information into the electronic recording system. This meant staff spent time duplicating information from the paper records into the electronic records. However, staff did not indicate this was a problem as the process for inputting the information was quick and efficient.
- Patient's records remained with the patient whilst they were receiving care and treatment at the centre. To protect patient confidentiality, records not in use were stored securely at the nurse's station.
- We looked at eight sets of notes, all of which were legible and detailed, and signed, timed and dated by the member of staff making the entry.
- All medical records were retained on site and archived after six -months.

Safeguarding

- The treatment centre had a named lead for safeguarding adults and a named lead for safeguarding children. Staff said safeguarding vulnerable adults and children training was a mandatory element of training for all staff at induction, and then through annual updates. Detail provided by the treatment centre showed compliance with safeguarding vulnerable adults level 1 mandatory training was 85% across the treatment centre. Compliance with safeguarding children level 1 mandatory training was 92% across the treatment centre. However, there was no breakdown of the figures for specific services or groups of staff. This meant we could not identify the compliance with these trainings for staff groups working in the surgical services.
- Staff demonstrated, through conversations, a good understanding about safeguarding processes and the action they needed to take if they suspected a patient was exposed to or at risk of being exposed to abuse. However, staff we spoke with did not have any examples of when they had had to follow safeguarding procedures.
- Staff explained that although the centre did not provide surgical services for children, safeguarding children was part of their mandatory training, as children were seen at the site in the Minor Injuries Unit.

Mandatory training

- All staff employed by Care UK were required to undertake mandatory training to ensure they had essential skills and knowledge to keep patients safe. Most of this was provided as on-line courses. Staff confirmed they completed mandatory training on-line and that they received electronic reminders when they needed to complete mandatory training. Mandatory training at the centre included basic life support, equality and diversity, fire safety, moving and handling, infection prevention and control, medicines management, the Mental Capacity Act 2008, safeguarding vulnerable adults and children, information governance, patient consent and clinical governance.
- Practical sessions were offered within Care UK for basic life support (BLS), immediate life support (ILS), advanced life support updates and manual handling.
- Records of compliance with mandatory training provided by the provider showed compliance across the whole of the Treatment Centre at April 2015 was 91%, which met the centre's target of 90% compliance. There was no breakdown of the figures for the surgical services or specific staff groups.
- Mandatory training was broken down by specific services or groups of staff. Records provided by the treatment centre showed that, for ward staff, six out of eight were 100% compliant with mandatory training, one was 75 % compliant and one was 70% compliant. For theatre staff three out of eight staff were 100% compliant, one was 92% compliant, one 90% compliant, and a further three were less than 70% compliant.

Assessing and responding to patient risk

- Procedures were followed to ensure only suitable patients were offered procedures/surgery at the Treatment Centre. GPs had access to the hospital's referral guide. This identified patients for whom treatment at the hospital was not appropriate due to the risk of needing extra support post procedure/ surgery that the treatment centre did not provide, such as overnight inpatient facilities or high dependency care. All patients, including those with a learning disability or dementia, completed a comprehensive preadmission/ treatment questionnaire to identify any health issues that would increase risks to their health post procedure/ operatively. Patients could be supported by family members or their carers, if required, to complete the questionnaires.
- All patients having surgery were assessed under the American Society of Anaesthesiologists (ASA) physical status classification system. This is a system for

assessing the fitness of cases before surgery. Patients with a score of two or above were not offered surgery at the centre as there was no provision for overnight or high-dependency care if it was required post operatively. Patients confirmed they attended a pre assessment appointment prior to their admission. Patients records evidenced this assessment process was completed prior to admission.

- Staff used the Five Steps to Safer Surgery checklist. This is an internationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures.
- Staff completed audit of the Five Step to Safer Surgery checklists used in the theatre suite each month. Records of the audits showed a good rate of compliance, not falling below 97%.
- Post operatively the centre used a nationally recognised Early Warning Score to identify patients who were at risk of deteriorating. This included observations of vital signs and the patient's wellbeing to identify whether they were at risk of deteriorating. The scoring system provided guidance for staff about what action to take if the patient was at risk of deteriorating.
- In the event of a patient's condition deteriorating, there were processes that staff followed. These processes ensured safe transfer of critically ill patients to the local acute NHS trust. This included processes for stabilising the patient's condition prior to transfer and service level agreements with the local acute NHS trust and the local NHS ambulance service. Staff described the processes followed to ensure safe transfer of critically ill patients to the local acute NHS trust. They confirmed they had received training about these processes and use of the relevant equipment. The treatment centre reported nine cases of patients transferred to other hospitals in the reporting period of April 2014 to March 2015. However, this data did not identify whether these were surgical patients or patients that had been treated in the MIU. Staff on the ward reported they could not remember the last time a patient had to be transferred to the local acute hospital.
- Rates for screening patients for likelihood of developing VTE were consistently at 100%, which is above the NHS Standard Contract quality requirement of 95%. Patients identified as at risk were prescribed preventative treatment as required.
- Reception staff were aware of patient and relatives needs and completed mobility risk assessments for the patient and relatives so they would have the appropriate support in the event of having to instigate an emergency evacuation.

Nursing staffing

- Staffing levels on the ward were calculated using a recognised safer staffing tool adapted to meet the needs of the treatment centre. Theatre and staffing schedules were planned six weeks in advance and were reviewed and amended in line with the workload. Staff confirmed there were always sufficient members of staff on duty.
- The wards had a board near the nurses' station detailing staffing levels, both expected and actual. On the day of our inspection the expected staffing levels were the same as the actual levels. Information provided by the service showed between April 2014 to March 2015 there had been no use of agency nursing or health care assistant staff on the ward.
- We viewed staffing rotas which showed staffing in theatres met the guidelines from the Association for Perioperative Practice (AfPP). Staff we spoke with confirmed there were always sufficient numbers of staff on duty.
- Due to the national difficulties with recruiting permeant theatre staff, agency staff were frequently employed to ensure safe staffing levels in theatres. Agency staff were usually 'block booked' so that the same member of agency staff worked in theatres. To promote safety of patients only one member of agency staff worked in a theatre. The theatre lead said that if this was not possible theatre lists were cancelled. The theatre lead believed having too many non-permanent members of staff on duty at one time compromised patient safety.
- Patients commented there were always members of staff available to provide support and care when they were needed.

Surgical staffing

- The centre employed four medical staff directly and a further 20 doctors worked at the centre under practising privileges or as part of a 'chambers' arrangement.
- The provider followed processes to ensure all surgeons who worked at the centre had the appropriate skills and competencies and received supervision and appraisals

- Consultants took clinical responsibility for their own patients. General anaesthetic procedures were carried out on morning lists, with the consultant who carried out those lists generally having outpatient clinics at the centre in the afternoon. This meant the consultant was on site to attend to any patient's clinical concerns during their immediate post-operative recovery at the treatment centre.
- An anaesthetist remained on site until the last patient was discharged.
- The centre did not provide a service overnight or at weekends, so there was no requirement for medical staff to be available overnight or at the weekend.

Major incident awareness and training

- Staff knew where to access policies, procedures and guidance to follow in the event of a major incident occurring.

Are surgery services effective?

Good

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.

We rated 'effective' as good.

Care was delivered in line with nationally evidenced based guidance. Patient outcomes were monitored through national quality monitoring schemes, corporate audits and locally developed audits. Patient reported outcomes measures were similar to other providers for groin hernia repair surgery, however readmission rates for groin hernia repair surgery were worse than those of similar providers.

Services were provided Monday to Friday. There was effective working between different staff groups employed by the treatment centre and other organisations that were involved in the care and treatment of the patient.

Staff were supported in their role through appraisals and supervision. Staff were encouraged and supported to participate in training and development to enable them to deliver good quality care. Informed consent for surgery was obtained from patients during outpatient consultations and re-affirmed with the patient by the operating consultant prior to surgery. Staff had an understanding of the Mental Capacity Act 2005, and its application to their area of work.

Evidence-based care and treatment

- Staff, in line with guidance from the National Institute for Health and Care Excellence (NICE), provided care. Records of departmental meetings showed NICE guidelines and results from recent studies were considered when planning any changes to services.
- Policies and guidelines, developed by the provider, were based on both NICE and Royal College guidance and were available to all staff. This included the use of early warning systems (EWS) charts to identify and take appropriate action when a patient's condition was deteriorating. (NICE guidance CG50).
- There was an audit programme set by Care UK that reviewed clinical practice against local policies. This enabled benchmarking both locally and within the Care UK group. Audits completed in July 2015 showed compliance with policies regarding perioperative hypothermia, recording of fluid balance, completion of the five steps to safety checklists, VTE assessments and training for safeguarding children's and adults was between 98% and 100%.

Pain relief

- Patient records showed that pre-operative assessment for all patients included details of post-operative pain relief. This ensured that patients were prepared for their surgery and were aware of the types of pain relief available to them.
- Staff assessed patient's pain as part of the EWS process using a nationally recognised scoring system.

Patients confirmed pain-relieving medicines were discussed and when required pain relieving medicines were provided for them to take home.

Nutrition and hydration

- Patients received written information prior to their admission advising the time they needed to fast pre operatively; this included when they could have their last meal and when they could have their last drink.
- Patients were offered drinks and light refreshment after their procedures

Good

Surgery

Patient outcomes

- The provider reported on the number of referrals and admissions to the hospital at clinical governance meetings. Between April 2014 and March 2015, there were 6,895 visits to theatres.
- For the same period, standardised 30-day readmission rates for cataract procedures was within the expected range.
- For the reporting period April 2014 to March 2015 there was one unplanned return to theatres.

Competent staff

- Data showed the appraisal rate for all staff during 2014 and 2015 was 100%. Data showed staff received supervision sessions on a monthly basis. Staff confirmed they received appraisals and supervision sessions.
- The provider followed processes to ensure visiting professionals had the necessary skills and competencies to carry out the care and treatment. The HR departments ensured the relevant information was obtained.
- The provider followed processes to ensure surgeons working under the 'chambers' agreement and those working under practising privileges had the appropriate skills and competencies and received supervision and appraisals. The HR department made checks against the relevant professional registers and the Disclosure and Barring Services. Surgeons working under the 'chambers' agreement and those working under practising privileges were required to provide evidence to Care UK's HR that they had completed relevant training and had received appropriate supervision and appraisals from their primary employer. There was a system followed for the treatment centre to provide information for these surgeons' appraisal processes. There was a system where any concerns with any surgeon substantively employed by an NHS acute trust or a 'chambers' who worked within Care UK were shared with Care UK and, where appropriate, management and resolution plans agreed. All new staff were required to attend complete an induction programme. We saw a comprehensive induction programme for a newly appointed consultant. Nursing staff confirmed they completed an induction programme.
- Nursing staff on the ward completed a comprehensive range of nursing competencies to ensure they had the skills to care for the range of patient conditions seen at the centre.
- Learning and development half days took place four times a year.

Multidisciplinary working (in relation to this core service only)

- The treatment centre had service level agreements for pathology and ambulance services. Care UK, the local NHS Trust and the local Ambulance service had an agreed pathway and process for the rapid transfer of patients to the local acute NHS Trust if required.
- Staff reported an ethos of multidisciplinary working with the medical, nursing, pharmacy and administrative staff working effectively together to achieve the best outcomes for patients.
- Due to the nature of the treatment carried out at the centre, no allied healthcare professionals such physiotherapists were employed in the surgical department. If patients required physiotherapy postoperatively, this was arranged through their individual GPs.

Seven-day services

- The centre provided day surgery Monday to Friday, so no out of hours services were required.

Access to information

- Patient records were accessible on the wards and departments. Staff reported no concerns with accessing patients' records.
- GPs received information about patients' treatment promptly. Discharge summaries were sent electronically at the time the patient was discharged from the centre.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consultants obtained consent from patients for surgery. Initial discussions regarding consent were commenced by a consultant at the outpatient clinic stage (we have reported this in the outpatient section of the report). Once admitted, consent was reaffirmed with the patient by the operating consultant. Consent forms appropriately detailed the risks and benefits to the procedures.

- Staff said they had completed training about the Mental Capacity Act 2005. Data provided by the treatment centre about compliance with training showed a 91% compliance rate for all staff with training about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards. However, there was no breakdown of the figures for specific services or groups of staff. This meant we could not identify the compliance with these trainings for staff groups working in the surgical services
- Staff demonstrated in conversations a good understanding about processes that would be followed if a patient had or was suspected to have reduced mental capacity to make informed decisions or to consent about procedures. This included carrying out mental capacity assessment in relation to the person making that specific decision, and involving the patient and all people important to the patient in making best interests decisions.

Are surgery services caring?

Good

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

We rated 'caring' as good.

During the inspection, we saw and were told by patients that staff were caring and compassionate. Patients and relatives commented positively about the care provided from all of the outpatient staff. Patients were treated courteously and respectfully.

Staff supported patients to maintain their privacy and dignity. Single sex theatre lists meant there was no risk of patient's dignity being compromised by having to share the environment with patients of the other sex.

Patients felt well informed about their procedures and care, including their care after discharge from the centre. There was a 24-hour patient helpline for patients to contact if they had any concerns following discharge.

Compassionate care

- We observed staff being compassionate and caring. All patients we had conversations with told us all staff were caring and kind. All patients we spoke with expressed positive views about their experiences at the treatment centre. Patients told us they were treated with "excellent respect and care," and were treated respectfully and professionally by nursing staff.
- Staff recognised the totality of patient's needs. Patients said staff considered their family, social and work needs when planning dates for their procedure or surgery.
- For the reporting period, October 2014 to March 2015 results from the Family and Friends Test showed constantly high scores in that patients would recommend the service to friends and family. However, there was a low response rate to this test of less than 30% of patients treated at the centre. There was no breakdown of the figures, so it was not possible to identify the significance of these figures to surgical services.
- In PLACE assessments published August 2015 the centre scored 82% for the way in which staff supported the privacy, dignity and wellbeing of patients.

Understanding and involvement of patients and those close to them

- Patients told us they felt well informed about their procedures and care. Discussions and decisions about their treatment were made at pre-operative assessment clinics. This meant when the patient was admitted to the centre they already had a good understanding about the care and treatment they were going to receive.
- We observed staff explaining discharge information and providing patients with support to ensure they had a good understanding of their procedure and onward care needs.
- Patients told us they had been provided information about their procedures at preadmission assessment appointments and that full information and explanations were given pre and post procedure/ surgery.

Emotional support

- All patients were allocated a named nurse responsible for their pre and post procedure or operative care. This supported continuity of care and reduced patient anxiety.
- If operative or procedure findings indicated, 'bad news,' there was quiet room provision for consultant led

discussion with the patient supported by nurse. In this situation, appropriate links were made to the NHS acute trusts in a timely manner to provide the appropriate support patients needed.
- Patients could contact a helpline after they were discharged from the centre for support and advice. This was available 24 hours a day and seven days a week.

Are surgery services responsive?

Good

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

We rated 'responsive' as good.

Surgical services were responsive to the needs of people: Patients were able to influence the choice of date for their surgery during outpatient's consultations. Patient admissions for surgery were staggered throughout the day so patients did not experience long waiting times for their procedure after arrival at the centre. The treatment centre met national targets for patients waiting less than 18 weeks after referral for treatment.

Services were flexible to accommodate patients individual needs, there were good examples of staff adapting procedures to meet the needs of patients with specific needs. However, the centre did not have literature in other formats or in languages other than English. This meant that patients who had difficulty reading or whose first language was not English might have difficulties fully accessing information.

Complaints were handled appropriately and there was an effective process for learning from complaints.

Service planning and delivery to meet the needs of local people

- The treatment centre provided elective surgery to NHS patients within the specialities of orthopaedics, general surgery, eye surgery and endoscopy. (Endoscopy services have been reported in the Outpatients and Diagnostic Imaging report.). Admission to the treatment centre for surgery followed strict referral criteria for people aged 16 and above who required routine non-urgent surgery.
- Surgical lists ran over five days with theatres operating Monday to Friday. Patients had choices over the date of surgery to best suit their needs.
- To assist in improving efficiency of the service across the organisation the 'Pisces' project had been implemented to review and suggest changes in practice to efficiency. Theatre staff spoke about the changes made to the running of theatres in response to findings of the Pisces project. This included later theatre start time. The project identified theatre lists were constantly starting late, because consultants were not able to get to the centre for the start of lists. Lists now routinely started half an hour later, which met the consultants' availability, and meant patients were not waiting unnecessary times prior to their procedure. Changes in practices made as a result of the findings of the project resulted in an increase in the number of cataract operations carried out during a session, which had increased from seven to eight. The project had identified the lack of prep rooms was slowing flow through theatres, as staff had to lay up the equipment in the theatre. As a result, an assessment of the environment was completed and room was identified to build two prep rooms, with the view to increasing the flow of patients through theatres. Staff, also reported, they now routinely took their coffee and meal breaks, where previously this had not always happened.
- The treatment centre did not provide surgical services to children.

Access and flow

- Dates for admission for surgery were discussed at patient's initial outpatient appointment. Patients were able to make individual choices about their preferred date of surgery. Patients spoke favourably about short waits for surgery.
- The treatment centre met national targets for patients waiting less than 18 weeks after referral for treatment (April 2014 to March 2015).

Meeting people's individual needs

- Staff described to us that patients were at the centre of the care received. Staff described feeling enabled to make changes to suit the patients' best interests and choices.
- Staff demonstrated in conversation a good understanding about meeting the individual needs of patients, such as patients with a learning disability,

patients living with dementia or those with physical or sensory disability. Staff spoke about adjustments they made to meet the needs of patients. For example, when needed, relatives or carers accompanied patients into the anaesthetic room. They could be with the patient in the recovery room when they were waking up from the anaesthetic to reduce their anxiety. This was predominantly offered to patients with a learning difficulty or living with dementia, but was offered to any patient who needed the adjustments.

- The ward consisted of eight bays with patient trolleys, seven reclining chairs and two recovery bays. Because of the lay out of the ward and the toilet facilities, surgical lists were arranged into female and male days. This meant there was no risk of mixed sex breaches (where females and males are treated and cared for on the same ward area).
- For patients whose first language was not English an interpreting service was available. However, conversations with some staff suggested that relatives would be used to assist in interpreting. Using relatives for translation purposes is not a recommended practice, as staff cannot be assured the patient has given consent for their medical information to be shared with their family member. However, staff on the wards said this rarely occurred, and there was usually no problem with accessing interpreting services.
- Patient information leaflets were only printed in English. The information was not available in alternative languages or in other formats such as pictorial, large print or braille. This meant patients who had difficulties reading the written word, or whose first language was not English might not have a full understanding of their care and treatment.
- PLACE assessments published in August 2015 scored the centre at 90% in relation to the environment meeting the needs of patients who had a dementia, which was in line with similar services.

Learning from complaints and concerns

- Complaints were responded to in line with Care UK's complaints policy. The registered manager had responsibility for overseeing the management of complaints with the individual department leads carrying out complaint investigations that were relevant to their area of work.
- There had been an increase from 46 complaints received in 2013 to 54 received in 2014. Between April 2014 to June 2015 there had been 17 complaints relating to surgical services. Themes noted were administrative concerns and unexpected delays in the provision of treatment. Records of complaint investigations showed each complaint was fully investigated responses provided to the complainant and where possible and appropriate actions taken to improve the service.

Are surgery services well-led?

Good

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.

We rated 'well-led' as good.

Staff knew of the vision and strategy of the service, which was to provide high quality service in a timely and effective way.

Governance processes at department level, treatment centre level and corporate level allowed for monitoring of the service and learning from incidents, complaints and results of audits across surgical services. Staff were positive about the leadership of the service.

Staff told us they were encouraged to improve services. Simple innovations, such as tick boards to identify which staff still required their breaks and which staff were presently on their break and "I'm next" signs to identify the next patient for surgery, had positive impact on the service provision.

Vision and strategy for this this core service

- Staff had a clear vision for the service and knew of the vision of the organisation. The vision was to provide high quality service in a timely and effective way.
- Staff spoke passionately about the service they provided and were proud of the facilities they worked in and the care they could offer to patients.

Good

Surgery

Governance, risk management and quality measurement for this core service

- There was a structured governance programme for the treatment centre, which included governance meetings locally at the treatment centre and regionally with other Care UK treatment centres.
- Records from governance meetings showed there were structured processes followed for monitoring outcomes, risks, staffing including sickness rates, vacancies, compliance with mandatory training and compliance with policies, procedures and national guidance. Records detailed actions plans resulting from governance meetings were monitored until completion.
- There were 13 risks identified on the treatment centre's risk register. Most risks were generic, having relevance to the overall running of the service rather than specifically to surgical services. Action taken to mitigate identified risks was detailed and there were appropriate review dates. Discussion with members of staff on the ward and the theatre areas evidenced they were aware of risk associated with their own clinical areas. Records of unit meetings showed staff discussed these risks and took action to mitigate identified risks.
- The provider followed processes to ensure visiting professionals had the necessary skills and competencies to carry out the care and treatment. This included the Medical Advisory Committee monitoring consultant's outcomes and ensuring consultants completed revalidation processes.

Leadership / culture of service related to this core service

- Senior managers were highly visible across the hospital. Staff described knowing them on first name terms and said they were approachable at all times.
- Staff spoke highly about their individual managers, about the support they provided to themselves and to patients. All staff said they were supported to report concerns to their managers who would act on their concerns. They said that their managers updated them on issues that affected the unit and the whole hospital.
- All staff demonstrated a culture of putting patients first. Ward staff described the culture of putting patients first and team working as reasons why the treatment centre was a good place to work. Reception staff demonstrated the culture of putting patients first. They described patients as "being in our care" until they went through to the clinical areas. This was demonstrated by the responsibility they took to ensure patients and relatives would have the required assistance to evacuate the building in the event of an emergency.

Public and staff engagement

- Staff asked patients to complete satisfaction surveys on the quality of care and service provided. The results were discussed at governance and unit meetings. Results including action taken were displayed in the patient waiting room.
- A patient forum group had recently been set up to enable patients to influence the development and running of the service.
- The treatment centre undertook staff engagement through various mechanisms. There were weekly messages to all staff from the treatment centre manager. There were weekly meetings and monthly meetings between the centre manager and the various leads. Each clinical area held their own meetings to pass on information and gather feedback from staff.

Innovation, improvement and sustainability

- Staff told us they were encouraged to improve services.
- The theatre lead had been supported by the centres senior management to set up half-day training sessions for all staff every three months.
- The Pisces project was supporting the treatment centre and surgical services to make changes to their practices and environment to improve patient flow and the effectiveness of the centre.
- Some innovations were very simple, but had a positive impact on the service. On the ward, the staffing board had a tick system to identify which staff still required their breaks and which staff were presently on their break. For ophthalmic patients a large bright tag was attached to the curtain around the chair they were sitting in that said "I'm next". This enabled all staff to quickly identify where the next patient for surgery was located, thus further improving patient flow.

Good

Outpatients and diagnostic imaging

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

Information about the service

A range of specialities, which include general surgery, orthopaedics, ophthalmology and endoscopy, provides outpatient services at St Mary's NHS Treatment Centre. Diagnostic imaging services were available at the treatment centre. Reporting of X-rays was provided by an external teleradiology company

The outpatient clinic comprised of five consultation/ diagnostic rooms. Any specialty could use any consultation room. Clinics were mainly consultant led, with the addition of specific nurse led and multi- disciplinary team clinics.

The endoscopy unit, located within the day surgery department, currently contained one dedicated endoscopy suite. Should a second list be required one theatre was made available. Only single sex sessions could be held given the current design of the endoscopy unit.

In the period April 2014 to March 2015, there were 4,849 outpatient appointments: 3,105 new appointments and 1,744 follow-up. The majority of outpatient clinics were held Monday to Friday, with occasional clinics held on a Saturday.

During our inspection, we visited the outpatient department, the diagnostic imaging department and the endoscopy unit. We spoke with six patients and 14 staff, including nurses, medical staff, healthcare assistants, radiographers, administrators, receptionists and managers.

Staff were observed giving care to patients. We also reviewed patient records and staff training records.

Diagnostic imaging services provided at St Mary's Treatment Centre include plain film radiology, ultrasound, Theatre Mobile Fluoroscopy.

The Medical Physics department based at an acute NHS trust provided support to the diagnostic imaging department. The diagnostic imaging department had a Picture Archiving and Communications System (PACS).

Service hours were as follows:

Outpatients: Monday - Friday 8.30am – 5.30pm

X-Ray: Monday - Friday 8am – 10pm

Ultrasound: Monday - Friday 8am - 6pm. When additional capacity was required, extra clinics were scheduled.

Good

Outpatients and diagnostic imaging

Summary of findings

The treatment centre provided a good outpatient service. Patients were positive about the care they received from staff, access to appointments and the efficiency of the service as a whole.

There were appropriate systems in place to keep patients safe. Staff reported incidents and learning was shared locally and within the wider organisation. We saw that outpatient areas were clean and that equipment was well maintained. Staffing levels were appropriate, with a low use of agency staff. Patient records were available for appointments and the department had timely access to test results.

There was good multidisciplinary team working. Staff told us there was good support in their role, with opportunities to develop their skills further. The Joint Advisory Group on GI Endoscopy accredited the endoscopy service, and it followed clear guidelines and conducted regular audits. Staff told us that patient reported outcomes were collected in some departments but this was not consistent across all of outpatients.

We observed that staff were caring, compassionate, and treated patients with dignity and respect. Patients told us they felt informed about their treatment and had been actively involved in decisions about their care. There was an interpreter service available for patients whose first language was not English. However, there was no literature available in other languages or other formats, such as large print. During the inspection, staff told us that the service had plans to provide information in other languages.

Staff managed and scheduled clinics appropriately. This ensured good availability of appointments for patients across all specialities.

Staff worked effectively in teams and was positive about the leadership of the service at both a local and senior level. There was an open culture and staff were encouraged to make suggestions to improve services for patients. A variety of methods was used to gather feedback from patients regarding their experience at the treatment centre.

Are outpatients and diagnostic imaging services safe?

Good

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

We rated 'safe' as good.

Patients in outpatients were protected from the risk of abuse and avoidable harm. Staff had a good understanding of how to report incidents and learning from incidents was shared at a local and organisational level.

Reports showed that staff undertook appropriate mandatory training for their role. The staff told us that they were supported to keep this up-to-date.

Clinical areas and waiting rooms were all visibly clean and tidy. Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested in line with manufacturer's guidance. Infection prevention and control audits showed practices were followed. Audits showed that these practices were regularly monitored, to prevent the unnecessary spread of infections. We saw that medicines were stored securely.

Staffing levels and the skill mix of staff was appropriate for the outpatient clinics. Staff told us that agency staff were not used, with staff working flexibly as a team.

Staff told us that patient records were available prior to appointments. Staff received simulation training, to ensure they could appropriately respond if a patient became unwell or a major incident occurred.

In diagnostic imaging, signage on the x-ray doors was clear and appropriate. Local rules and systems of work were seen and in date.

Staff were able to demonstrate the procedure in the event of a medical emergency. There was a green button on the hospital computer system that when clicked, there would be an emergency response from staff in the Minor Injuries Unit (MIU), at least one member of staff from MIU was Advanced Life Support (ALS) trained.

Completed records that showed daily quality assurance (QA) tests for x-ray equipment were undertaken.

Good

Outpatients and diagnostic imaging

There were two nominated Radiation Protection Supervisors (RPS) and both had received training from the medical physics team at St George's University Hospitals NHS Foundation Trust. Records that showed update training had taken place every three years.

A senior radiographer reviewed all x-ray requests prior to X-ray.

There were good communication and support links with medical physics team at St George's hospital.

Incidents

- In all outpatient areas staff were aware of their responsibly to report incidents. Staff reported incidents either via an electronic reporting system or to their manager who then logged the incident on the reporting system. Staff we spoke with were confident to report incidents and challenge poor behaviour by staff at any level, medical or nursing, if they were concerned about poor practice that could harm a person.
- The treatment centre reported, there were no serious incidents or clinical incidents in outpatients (April 2014 to March 2015).
- There was evidence of local learning from incidents within departments, through feedback at team meetings. Staff unable to attend the meeting were provided with the minutes.
- In diagnostic imaging, there were systems and processes in place for post-incident feedback. There was an incident reported when 19 x-ray requests were deemed to have been lost in the system. On investigation, it was due to an error in the link between the fax machine and the email. This was resolved and to minimise the risk of this happening again, requests are now printed as a back-up.
- In diagnostic imaging, we observed that Incidents and shared learning, is an agenda item on the monthly departmental meeting.
- In diagnostic imaging there were clear processes of reporting IR(ME)R incidents to the medical physics team. Evidence was seen that confirm the correct process had been followed.

In diagnostic imaging, best practise is to screen lead protective coats within fluoroscopy annually for any evidence of damage. Staff told us that visual inspection of lead coats took place but not screening.

- The Duty of Candour requires healthcare providers to disclose notifiable safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incidents falling within these categories must be investigated and reported to the patient, and any other relevant person, within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- We observed signed training logs that confirmed that senior staff had received information and training on the Duty of Candour.
- In diagnostic imaging a professional member of staff was able to describe the principles of Duty of Candour and would contact a patient and provide truthful information if errors had been made.

Cleanliness, infection control and hygiene

- All outpatient areas, both waiting rooms and clinical rooms were visibly clean and well maintained. The environment in both waiting areas was light, airy and calm.
- Hand sanitizer points were available for people to use. This encouraged good hand hygiene practice. There were also posters in waiting areas and at the main reception encouraging patients to clean their hands, to minimise the spread of infection. The staff were observed to be adhering to 'bare below the elbow' guidance to enable thorough hand washing and prevent the spread of infection between staff and patients.
- Personal protective equipment (PPE), such as gloves and aprons, was readily available for staff in all clinical areas, to ensure their safety when performing procedures. We saw staff using them appropriately.
- There was a lead for infection control in the outpatient area. We saw regular infection control audit had taken place. We saw 100% compliance of recent hand hygiene audit. Staff we spoke with were aware of the outcomes from audits and changes needed to practice, through information sharing at team meetings.
- In-line with current best practise the treatment centre had a 0% MRSA rate (April 2014 to March 2015), which was achieved through an effective MRSA screening programme. Patients had an MRSA swab as part of the pre- assessment process. In the event of a positive MRSA swab, there was a clear pathway to follow, covering the

required medicines, review date and appropriate next step dependent on the outcome of a further swab. This service was nurse-led, with appointments arranged directly with the patient.
- In diagnostic imaging the department overall appeared clean. Staff were responsible for maintaining the cleanliness of the equipment in accordance with infection prevention and control (IPC) standards. Cleaning schedules for all areas were seen which were complete with no historical gaps.
- We checked PPE equipment including lead coats during the inspection: they were externally clean and in good condition.

Environment and equipment

- Equipment was visibly clean. We saw labels on equipment with the last service date and review date. They also had an asset number to enable easy tracking of the item, if it required servicing or maintenance. Portable appliance testing was also undertaken annually. Staff we spoke with were clear on the procedure to follow if faulty or broken equipment was found. Broken or faulty items were to be removed from clinic area to prevent further use.
- Staff did not report any concerns regarding availability or access to equipment. Staff told us that managers were supportive to requests for new equipment.
- In outpatients, single use items were stored in clearly labelled drawers in sufficient numbers. The check of a random sample found all items to be in date.
- In endoscopy, the Theatre Sterile Supply Unit (TSSU) undertook decontamination of scopes. There was a recording system in use to ensure the traceability of endoscopes. This was compliant with British Society of Gastroenterology guidance on decontamination of equipment for gastrointestinal endoscopy (2014).
- Staff followed JAG guidelines with regard to endoscope decontamination. Staff identified, and transferred, dirty scopes to the decontamination suite adjacent to the endoscopy room. We saw evidence of scope traceability in patient healthcare records. Following decontamination, clean scopes were stored in locked cabinets prior to use. The Unit had a scope maintenance contract with the manufacturer, who also provided staff with training in the correct use of the endoscope equipment.
- The housekeeping team managed rubbish disposal with at least daily checking of the dirty store. There was clear labelling of clinical waste bins and all sharp boxes checked in clinical rooms contained the start date.
- Clinical room had call bells for staff or patients to summon assistance, should a patient become unwell. Support would come from either that department or the emergency response team, depending on the severity of the patient's illness. The hospital computer system also had an on-screen emergency call bell that staff could use to call for assistance. Checking of the call bell system took place once a week in a clinical room to ensure it was working and the outcome logged and reported if necessary.
- Resuscitation equipment was clean, well maintained and ready for use in an emergency. Daily checks took place on the trolleys to ensure the seal had not been broken. Logs confirmed that daily reviews took place. Checks of all contents in the trolley took place monthly. A checklist was used and disposable items due to expire the following month were thrown away and replaced.
- During the course of our inspection, we observed that specialised personal protective equipment was available for use within radiation areas. We saw staff wore personal radiation dose monitors.
- Both x-ray rooms in diagnostic imaging are 10 years old and are in good condition.

Medicines

- Medicines were stored safely in outpatients. We saw locked medicines cupboards. The lead nurse on duty held the keys. Staff we spoke with knew who held the keys. We saw locked refrigerators. Logs confirmed temperatures checks took place daily, to ensure medicines were stored at the correct temperature.
- In outpatients, FP10 prescription pads were stored and managed securely. We saw a log, which confirmed traceability of serial numbers on prescription pads.
- In endoscopy, there was a patient group direction (PGD) for the administration of a laxative, by a registered nurse. This was provided during pre-assessment for patients to take at home, prior to undergoing an endoscopy. A PGD provides a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine (s) to a pre-defined group of patients, without them having to see a doctor. A PGD is used in situations that offer an advantage to patient care, without compromising

patient safety. Care UK developed the PGD had been developed with input from the head and divisional lead pharmacists and a medical director. The PGD had been appropriately signed, was in date and in use by staff.

- Patients commented to us positively on having received a clear explanation of their treatment plan and any necessary medicines they needed to take. Specialist nursing staff also focused on information about medicines as part of their consultations. This included patients needing treatment following a positive MRSA swab or requiring step down treatment when on blood thinning medicines. The latter group were also called to confirm the last day they had taken their warfarin, prior to starting the next stage of the treatment process. There was no written pathway in main outpatients for nursing staff to follow for the management patients on blood thinning medicines. The same two nursing staff who fully understood the pathway ran the clinic, but there was a potential risk to patients if neither of these staff were present.
- There were no medicines or contrast media used or stored in the x-ray department.

Records

- The onsite room, in which patient records were stored, was secure. OPD staff accessed the locked room via a keypad. OPD staff collated patient notes seven days prior to clinics. One day prior to clinic, crosschecking of clinic lists took place, to ensure the records for any patients added more recently to the clinic list were available for their appointment. Staff we spoke with reported notes were always available
- In outpatients, a health care assistant was responsible for cross checking the patient list with the available records. OPD staff identified missing records to the administration team, who found these records. OPD staff returned all records to the administration office at the end of the day and crosschecked with the clinic list. A medical secretary received the dictation from the doctors and typed the clinic letters.
- Patient records in outpatients were stored in lockable trolleys or kept in the clinic room, to ensure safe storage of records and maintain patient confidentiality. Some consultant clinics and nurse pre- assessment used electronic records. Patients who had not had contact with the treatment centre for a minimum of four months, had their records scanned at a secure off-site facility to ensure they were available electronically for future appointments.
- During inspection, we reviewed a random sample of three records in endoscopy. We found they all contained the referral letter and all appropriate documentation, including scope traceability. We saw records completed to a high standard.
- There was a records management and archiving policy, which followed Department of Health guidance for the retention of clinical records.
- At the time of inspection, in diagnostic imaging, we saw safe and secure management of patient personal information and medical records.
- In diagnostic imaging, we looked at 12 patient request forms. All included comprehensive details of the patients' medical history.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store medical images of patients. This system was available and in use across the hospital.
- There were paper requests for all radiology examinations. Scanning of paper requests onto the Radiology Information System took place after the examination. There was an electronic scheduling system for appointments and patient tracking.

Safeguarding

- Safeguarding training, both children and vulnerable adult, was mandatory for all staff, the level of training determined by clinical role. Staff we spoke to were aware when to raise a concern and the process they should follow, but had not had to raise any recent concerns. There was access to the safeguarding policy for children and adults on the intranet, should staff need to refer to it. Data detailing training provided by the Treatment Centre showed compliance with safeguarding vulnerable adults (level 1) mandatory training was 85% across the Treatment Centre. Compliance with safeguarding children (level 1) mandatory training was 92% across the Treatment Centre.
- There was a cross checking system in outpatients to ensure the correct patient identity. Reception staff checked patient details on arrival. Nurses, when calling

through the patient, carried out a further check. The nurse rechecked the patient details once in the consultation room, to ensure the patient, their notes and any electronic records related to the same patient.

- The diagnostic imaging department has a six-point patient ID check; Patient name, date of birth, address, body area, justification of test and date of last x-ray. On arrival to the department patients fill in their details on the form; the radiographer compares both forms to confirm the check. The department adopted this practise following a patient raising concerns about verbally giving the details at the reception and the risk of breach of confidentiality. The radiographer, following guidelines developed by IR(ME)R, then checks the details of the patient in the x-ray room prior to the x-ray. The radiographer then ticks each detail on the request form and signs the form as checked.
- Healthcare assistants received chaperone training to offer support to patients as needed.
- We reviewed seven request forms in diagnostic imaging. We saw that the radiographer checked four of the seven forms.
- We asked two administrative staff in diagnostic imaging about responsibilities to safeguard adults and children. Given a scenario, both were able to give an appropriate response on how to respond and report the incident. Both were aware of the member of staff responsible for children's safeguarding in the hospital.
- We saw, in diagnostic imaging, a process where safeguarding a vulnerable child had been followed.

Mandatory training

- Staff completed a number of mandatory training modules as part of their induction and updated them in line with current policy. This included infection prevention and control, fire safety and information governance. The training was mainly via e-learning packages, with practical sessions for basic life support and manual handling. Across the treatment centre compliance with mandatory training, was at least 91% (period February 2015 to April 2015). There was no breakdown of data provided to demonstrate compliance with mandatory training for the different outpatient areas or specific staff groups.
- There was a lead in the treatment centre for mandatory training. The lead took responsibility for maintaining the staff-training matrix and reminded staff to update training as needed.
- No staff we spoke with reported any issues finding time to complete their mandatory training.
- The medical physics team provide radiation protection training for the Radiation Protection Supervisors (RPS).

Assessing and responding to patient risk

- The outpatient area had its own hazard register. We saw that potential hazards, people affected, and assessment of risk, and controls that had been put in place to reduce the level of risk.
- Staff in outpatients were aware how to respond to patients who became unwell and how to obtain additional help from colleagues, to help them care for the patient. Staff had training in basic life support, with some staff trained in intermediate life support.
- A consultant anaesthetist was always on duty to provide senior medical cover, which provided support to the outpatient's staff, if a patient became unwell. Should a patient become medically a transfer to the inpatient ward or to the local acute NHS Trust would take place in line with the treatment centre emergency transfer policy.
- The Radiation Safety Committee ensures compliance with ionising and non-ionising radiation legislation regarding clinical radiation procedures and supporting activities. This is their principal function. The committee meets annually and the Radiation Protection Supervisor (RPS) receives minutes and actions. All staff had access to folders within the department containing these minutes. The minutes are also presented at the Hospital Quality Assurance meeting.
- In diagnostic imaging, there are two appointed and trained RPS. Their role was to ensure that equipment safety and quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures.
- In diagnostic imaging, there was clear signage outside the x-ray rooms for staff and patients.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed them before exposure to radiation.

Good

Outpatients and diagnostic imaging

- The last menstrual period (LMP) policy was up to date and met IR(ME)R requirements. Examples of completed LMP forms were seen and scanned onto the radiology information system to ensure patient and foetal safety.

Nursing staffing

- Nursing cover was sufficient in all outpatient areas. There were 4.2 whole time equivalent nursing staff and 1.8 whole time equivalent healthcare assistants. There were no set guidelines on safe staffing levels for outpatient clinics. Once clinic information had been placed on the booking system, OPD staff reviewed staffing requirements six weeks prior to clinics. This determined the skill mix of nursing staff and healthcare assistants.
- Healthcare assistants were cross-trained to provide clinical support to a number of clinics, such as ophthalmology and endoscopy. The use of agency staff was actively avoided in outpatients, because these staff may not always have the appropriate competencies for the number of different speciality clinics that were held.
- For all outpatient areas, there was no agency staff cover needed for the period April 2014 to March 2015.
- In endoscopy, staffing levels met the current Joint Advisory group on GI Endoscopy guidance (JAG) with three staff always present to support the endoscopist.

Medical staffing

- The Treatment Centre at the time of the inspection directly employed four medical staff, with 20 working under rules or practising privileges. There were sufficient consultant staff to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the administration team, based at the treatment centre.
- Staff told us that medical staff were supportive and advice could be sought when needed.
- X-ray reporting for the treatment centre has been outsourced. A consultant radiologist provides support. Staff can contact the consultant by email and telephone.

Major incident awareness and training

- Staff were aware of their roles and responsibilities during a major incident. A Business Continuity Plan was in place for the treatment centre.
- Every department had a fire marshall who liaised with the manager in charge in the event of a fire, to ensure safe evacuation of patients, staff and visitors.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

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.

We inspected but did not rate 'effective' as we do not currently collate sufficient evidence to rate this.

National guidelines were used, but there was limited evidence that clinical audits were being undertaken in all outpatient areas, including recording of patient reported outcomes.

Staff were supported in their role through appraisals. All staff were appraised. Staff were encouraged to participate in training and development to enable them to deliver good quality care.

There was evidence of multidisciplinary team clinics and one-stop clinics, reducing the number of appointments patients needed and enabling prompt access to treatment. A well-structured consent process, with written information, was available for all patients.

Patients requirement for pain relief were met appropriately during a procedure or investigation. Clinics were held Monday to Friday, with occasional Saturday clinics.

The NHS six-week diagnostic target for ultrasound was being met. At the time of inspection the waiting times were 5 weeks and 4 days – both admin staff and radiology manager were able to provide this information. Additional scanned sessions were scheduled when required to sustain the achievement of the six week target

X-ray services provided were a walk in service for both GP patients and outpatients.

The turn-around times (TAT) for x-ray reports were all within 48 hours and, on the whole, this happened in 24 hours in this service . The only causes for delays were requests for previous images for comparison.

Good

Outpatients and diagnostic imaging

The sonographers reported ultrasounds. An external firm quality checked 10% of the ultrasound reports together with 'spot' images.

The department were considering registering for the national Imaging Services Accreditation Scheme (ISAS) in the future.

Named consultant radiologists, within Care UK, discussed and highlighted any discrepancies in the radiology diagnosis.

'Are you pregnant?' notices advising patients to inform the radiographer were in the patient changing cubicles in English and two other languages.

Evidence-based care and treatment

- Staff in all outpatient areas reported they followed national or local guidelines and standards to ensure patients received effective and safe care.
- The endoscopy department participated in the Joint Advisory Group on GI Endoscopy (JAG). They were accredited to level A (the highest rating possible), at the time of our inspection and delivered the service to the required standards according to the guidance. JAG accreditation requires a unit to demonstrate high standards of quality, safety and patient care. Regular audit confirms maintenance of these standards.
- In outpatients, the pre-assessment process incorporated National Institute for Health and Care Excellence (NICE) guidance on the use of routine preoperative tests for elective surgery.
- In diagnostic imaging we reviewed clinical audit plans and results. For example, evidence of regular audits of radiation exposure and diagnostic reference levels checks. We saw that these audits were within national guidelines and results were displayed in the imaging department.
- IR(ME)R audits are undertaken as required by the regulations for example the documentation of x-ray requests. Outcome of audits was satisfactory reaching above 95%.

Pain relief

- Discussion took place with the patient regarding pain relief options. This either happened at the pre-assessment appointment or before any medical procedure took place.
- The use of local anaesthetic during procedures enabled patients to return home the same day.
- OPD staff provided written advice to patients on any pain relief medicines they may need to use at home, during their recovery from their procedure.

Patient outcomes

- Limited data was available on patient reported outcomes for outpatient services, as this was only recorded and analysed by a few services within the treatment centre.
- Patient comfort scores for colonoscopy were collected as part of the JAG standards.

Competent staff

- Patients told us they felt staff were appropriately trained and competent to provide the care they needed. Staff confirmed they felt well supported to maintain and further develop their professional skills and experience.
- In the period April 2014 to March 2015, 100% of outpatient nursing staff and healthcare assistants had received an appraisal. In the same period, 100% of nurse's registration status had been verified to confirm they could continue to practise.
- There were appropriate systems in place to assure the hospital leadership team all doctors had the necessary qualifications and competencies. For example, medical staff underwent relevant employment checks, to ensure fitness to practice in their speciality. Appraisals and revalidation were conducted and checked by the relevant medical director depending on the consultants' employer.
- There were appropriate systems in place to assure the hospital leadership team that all nurses had the necessary qualifications and competencies. For example, nurses identified a number of Care UK competency packages they had used to support their development, such as nurse led cannulation and nurse consent in endoscopy. Staff competencies we reviewed had been fully signed off, prior to the nurse being able to undertake the procedure or process without supervision.
- Nurses were able to pre-assess patients categorised as level one using the American Society of Anaesthesiologists (ASA). This scoring system considers the patients level of health and therefore, the likelihood

of any complication during surgery. Consultant anaesthetists always saw level two and three patients to ensure patient safety and appropriate planning for their operation.
- In diagnostic imaging, staff appraisals were up to date. Staff spoken to felt their appraisal was positive with development plans for the future. All of the staff we spoke to were up to date with their mandatory training.
- The office manager tracked mandatory training for all staff. The office manager emails individual staff where training if required. Office manager presented a spreadsheet with details of all mandatory training showing an achievement of 91% against a target of 100%.
- A sonographer we spoke with, in diagnostic imaging, confirmed availability of CPD [Continual Professional Development]. Diagnostic imaging staff are able to attend the National ultrasound conference – British Medical Ultrasound Society.

Multidisciplinary working

- There was evidence of effective multidisciplinary (MDT) working in all outpatient areas, ensuring efficient delivery of care and treatment to patients. This reduced the number of times they needed to attend for an appointment. Patients we spoke with confirmed they had been routinely offered access to MDT, nurse-led and one-stop clinics.
- Patients could get their x-ray completed on the same day as their appointment as part of the one-stop shop. Results were immediately available electronically for consultants to view in the clinic.
- From the care we observed, there was effective team working, with strong working relationships between all staff groups.
- The diagnostic imaging department have a direct link with the nominated consultant radiologist for Care UK.

Seven-day services

- Clinics in outpatients were held on Monday to Friday, with clinics generally running from 8.30am to 5.30pm. Patients we spoke to reported good access to appointments and availability at times that suited their needs.
- In diagnostic imaging seven-day x-ray services are provided to ensure an imaging service is provide for the minor injury clinics.

Access to information

- Staff we spoke with reported timely access to test results such as from bloods and diagnostic imaging. Results were available for the next appointment, or for certain clinics, during their visit. Prompt discussions took place with patients, and treatment plans devised, on the findings of investigations.
- There were appropriate systems in place to ensure safe transfer and accessibility of patient records if a patient needed to be transferred to another provider for their treatment.
- Patient notes were always available to ensure continuity of care. Files were colour-coded by specialty to allow for ease of recognition.
- We saw a range of information leaflets available and provided to patients in relation to diagnostic imaging.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Support was available for patients to enable informed decisions, about their treatment, prior to giving consent. Information leaflets given to patients included the risks and benefits of the proposed procedure or surgery. Patients received information prior to one-stop appointments, such as endoscopy. This allowed patient to read the information and, if understood, give informed consent when they came for their appointment. Patients were given adequate time at their first appointment to ask questions about their treatment.
- Mental Capacity Act training was part of the mandatory training programme. Staff we spoke with were aware of how to apply this training, but had needed to use it infrequently. They were able to identify which was the appropriate consent form to use for a patient who lacked capacity to consent. The majority of general x-ray procedures were carried out using implied consent from the patient.
- There are no interventional procedures carried out in the diagnostic imaging department. The surgical team managed joint injections as day cases in theatres.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Good

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

We rated 'caring' as good.

During the inspection, we saw and were told by patients that staff in all outpatient areas were caring and compassionate. Patients and relatives commented positively about the care provided from all of the outpatient staff. We observed staff treating patients courteously and respectfully.

Patients commented that the facility as a whole had a very good reputation within the local community.

We saw that staff maintained patients' privacy and dignity at all times. Staff kept patients up to date with and involved them in discussing and planning their care and treatment. Patients were able to make informed decisions about the treatment they received. Staff listened and responded to patients' questions appropriately.

Patients and relatives told us of the emotional support received from staff.

Compassionate care

- We observed that patient's dignity was maintained and that they were afforded privacy at all times. Reception desks were a sufficient distance away from waiting areas so patients could speak to reception staff without being overheard. There were signs behind reception desks giving the names of the receptionists. Receptionists in both the outpatient department and day surgery unit stated that they believed their role was to look after patients observe them whilst in their area.
- We observed all clinical activity was provided in individual consulting rooms with the doors closed, to maintain privacy and confidentiality.
- Signs offering patients a chaperone were displayed clearly in waiting areas and clinical rooms. Healthcare assistants received chaperone training, so they could support patients when needed.
- Throughout the inspection, we saw staff speaking in a calm and relaxed way to patients. Patients told us they were helpful and supportive. They told us staff always showed concern and understanding for their situation and were sensitive to any needs or worries they had.
- In all outpatient areas, we saw staff had received compliments on the care they provided to patients, in the form of thank- you cards.
- The treatment centre recorded consistently high friends and family test scores above 85 (out of 100) in every month of the reporting period October 2014 to March 2015. The response rate was 30% for this period, and the Hospital Director was looking at ways to improve this response rate.
- In diagnostic imaging, we observed staff being polite and considerate to patients.
- The diagnostic department actively encouraged feedback using the Friends and Family forms. In the past six months, this had increased from 250 to 650 per month. The results of the Friends and Family test were displayed in staff areas so that all staff could appreciate the positive comments and learn from others.

Understanding and involvement of patients and those close to them

- Four patients told us information, both verbal and written, to enable then make an informed decision about their care and treatment had been provided. There had been sufficient time at their appointment for them to discuss any concerns. They all commented on the quick service they received from referral to appointment and/or treatment.
- Outpatient nurses supported patients at certain clinics, offering help with, for example, management of blood thinning medicines in the run up to surgery.
- Staff commented how they had used the services themselves and how that had given them an interesting perspective on being a patient.

Emotional support

- Patients and relatives commented that they had been well supported emotionally by staff, particularly if they had received upsetting or difficult news at their appointment.
- When interviewing staff it was clear they were passionate about caring for patients and put the patients' needs first.

Good

Outpatients and diagnostic imaging

- Staff told us they always offered to chaperone patients undergoing examinations. We saw records, which confirmed patients had been supported in this way.

Are outpatients and diagnostic imaging services responsive?

Good

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

We rated 'responsive' as good.

Services were planned and delivered in ways that met the needs of the local population. Clinics were generally held on weekdays, and patients told us that there was good access to appointments at times that suited their needs.

There was information on specific procedures or conditions, but this information was only in English and not in other languages or formats, such as braille. Clear information was on display regarding the interpretation services available.

Patients were encouraged to provide feedback after their outpatient appointment by completing the Friends and Family test. Results were displayed in waiting areas and included actions taken in response to patients making suggestions or raising concerns in the form of 'You Said, We Did!' posters.

Service planning and delivery to meet the needs of local people

- Services were well planned and the facilities appropriate to support the running of clinics, for the different clinical specialities providing services for patients at the treatment centre. The current layout of the endoscopy unit meant only single sex sessions could run.
- Patients were sent appropriate information prior to their first attendance, containing information such as the consultant or clinic they were to see, length of time for the appointment and written information on any procedures that may be performed at the first appointment.
- A pre-assessment administration clerk worked 11am until 7pm, Monday to Friday, enabling access to patients who might not be able to respond during the normal working day. The two patient schedulers worked one day a week until 7pm, for the same reason.

Access and flow

- The patient schedulers used robust systems to manage the scheduling of clinics. Patients could book their appointment online, visit or ring the booking centre, enabling them to choose an appointment time that suited their needs.
- Patients confirmed good availability of appointments was good, at times that suited them.
- The majority of patients left with their next appointment date or if appropriate, an admission date for surgery. Patients were very complimentary about the efficiency of the service.
- The clinics we observed ran to schedule. Staff told us if there were delays, they would speak to patients and keep them informed.
- Waiting times for first appointment, at the time of inspection were three weeks or under for all specialities. The national referral to treatment time (18-week target) was met for all specialities.
- Patients were reminded of their appointment through a computer generated text or a personal telephone message the day before their appointment. Patients generally had additional tests performed on the day of their appointment.
- The 'did not attend' (DNA) rate for outpatient appointments was around 4%, which was better than the England average of 7%. There was no evidence of missed appointment audit. In outpatients, they had started to capture data to allow audit of this and consider changes to improve patient attendance rates.
- All patients had access to a 24-hour helpline, if they had concerns they wished to discuss following their appointment or treatment.
- The diagnostic imaging department provides a same day x-ray service for outpatients, GP and MIU patients.
- Diagnostic imaging provided a seven-day x-ray service for the MIU clinics.
- In diagnostic imaging the service we did not observe any evidence that the service was responding to the long waits GP patients were experiencing.
- In diagnostic imaging, there was a notice board to advise how long patients could expect to wait. The

board indicated a wait of one hour at the start of the clinic. Staff confirmed, when asked that the wait time on the notice board was standard. Staff did not alter the wait time to reflect the actual wait time in the clinic.

- In diagnostic imaging, was saw that priority was given to Outpatients and MIU patients over walk in GP patients. As a result, the GP patients could be delayed and, on the day of the inspection, GP patients were waiting over an hour. When questioned about the concern, we heard that staff said patients were informed they might have to wait an hour after their arrival. Patients were given the option to book an appointment to enable them to return at another time and reduce further waiting.

Meeting people's individual needs

- Staff recognised the need for supporting people with complex or additional needs and made adjustments wherever possible.
- There was sufficient seating in waiting areas, with a television. There were no catering facilities on site, although there were vending machines within the outpatient waiting area. There was a café located in another building located within the hospital campus.
- Clinics were well signposted from the main reception desk in the treatment centre.
- All written information, including pre-appointment information was provided in English. Patients who spoke another language beside English were provided with access to an interpreter .The treatment centre did not use family members as interpreters.
- A sign was located on the reception desks written in multiple languages advising patients to ask for an interpreter if needed. The pre-assessment process included a check regarding the need for an interpreter.
- Easy read information leaflets were not available. We saw nothing on display to advise patients how to access information in large font, braille or audio, nor was this printed on any leaflets, other than the patient information guide. The information leaflets on procedures in outpatients were in a particularly small font size, making it difficult for patients to identify which leaflet they needed to read.
- Appointment times for first appointments were longer than those for follow-up appointments, to give patients sufficient time to ask questions, and for information to be obtained. Waiting list times were specialty specific.
- The diagnostic imaging department tried to accommodate non-medical requirements when booking appointments and were able to accommodate clinical needs.

Learning from complaints and concerns

- Patients were actively encouraged to leave comments and feedback via the use of the Friends and Family Test. Patients were offered both to provide feedback in either paper or electronic tablet format. OPD staff displayed results from collated data in waiting areas. Patient feedback was included in the 'You Said. We Did' posters.
- We observed comment cards and the complaints guide in the main reception area. In the outpatient waiting areas, posters advised patients to ask for a card. Prior to their appointment patients received the patient information guide. This guide contained information on how to make a complaint.
- Staff we spoke with were aware of the complaints procedure and to whom to report concerns. Staff shared learning from complaints at team meetings, with staff also able to attend clinical governance meetings.
- In diagnostic imaging, we saw examples of learning from complaints. A patient had complained about giving personal information at the reception. As a result of this, patients are now asked to complete a form with questions about their personal details rather than tell the receptionist. In a further example, a patient complained that an urgent request from a GP was downgraded to routine. The department are currently undertaking a survey by contacting the GP when the plan is to change an urgent request to routine and will respond accordingly.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services well-led?

Good

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.

We rated 'well-led' as good.

The outpatients department was well led. The department had a vision to provide high quality service in a timely and effective way. Staff and managers were able to articulate this vision. Staff felt supported and were able to develop to improve their practice. There was evidence of an open and supportive culture.

The department supported staff who wanted to be innovative. Patients were given opportunities to provide feedback about their experiences and this was used to improve the service.

Staff in the outpatient department stated they were well supported by their managers overall. They were visible and provided clear leadership.

Sonographers are risk assessed to minimise Repetitive Strain Injury (RSI), which is a recognised risk nationally in this clinical job role. Scanning lists have been adjusted to allow 'rest' times. This has meant extended list times. The clinic lists are also booked with a mixed case type to reduce the risk of RSI.

Vision and strategy for this service

- Staff spoke highly of the service they provided and were proud of the facilities they worked in and the care they could offer to patients.
- Staff had a clear ambition for the service and were aware of the vision for the organisation. The vision was to provide high quality service in a timely and effective way. Vision and strategy plans were on display on notice boards within the staff room.
- In the diagnostic imaging department, there were clear governance structures and defined reporting structures to senior managers.
- In diagnostic imaging, there was effective audits carried out and change of working practise made in response to this. The diagnostic imaging team advised good support from the medical physics team at St Georges Hospital.

Governance, risk management and quality measurement

- There was a treatment-centre-wide risk register which was updated regularly and also a hazard register for each department, identifying specific risks in that area which may affect staff, patients and visitors.
- Radiology did not have its own risk register. There was a lack of knowledge about risk management: for example, the risk of breaching the ultrasound waiting time diagnostic target was not on the register. During the inspection we made managers aware who then approached senior management to place the diagnostic target on the register.
- We saw minutes of governance meetings that covered areas of good practice and risk within the outpatients department. Staff were invited to and attended clinical governance meetings so they were aware of risks within their own department
- There was a quality notice board in the staff room. This gave quality information for the treatment centre, and had a notice inviting staff to weekly open sessions with the quality improvement manager.
- Sonographers are risk assessed to minimise Repetitive Strain Injury (RSI), which is a recognised risk nationally in this clinical job role. Scanning lists have been adjusted to allow 'rest' times. This has meant extended list times. The clinic lists are also booked with a mixed case type to reduce the risk of RSI.

Leadership of service

- There was an outpatient department lead nurse and each area had a lead.
- Staff were positive about the leadership at senior management level. They told us the leadership team were visible and approachable. They felt concerns were listened to and where possible acted upon.
- Staff felt their immediate manager had the appropriate skills to be able to lead and run their department, and was supportive. Staff did comment that they felt that some management were not always aware of the daily challenges within outpatients.

Good

Outpatients and diagnostic imaging

- Leads in outpatients and diagnostic imaging told us identified constraints to their services. They suggested changes which could be made to maintain the standard of care provided to patients. The hospital director gave regular feedback on service performance.
- Since March 2015, there has been no sickness among the office staff.
- Senior staff in diagnostic imaging told us they were happy working for the unit. The staff that we spoke with felt supported by senior management
- In diagnostic imaging, the managers were promoting the standards of the department to encourage new recruitment, which in turn can bring new ideas and development into services.

Culture within the service

- The culture within the service was open and transparent. Staff told us the hospital director met with staff, across the service, on a weekly basis to discuss the service and feedback received from patients and carers.
- Staff told us they felt listened to and respected. Staff told us they felt they could raise their concerns. Staff told us that concerns were appropriately investigated.
- All staff we spoke with commented on the good service that they were able to provide for patients, through good teamwork and support within departments. Staff were clearly proud to work at the treatment centre.
- All staff we spoke with in diagnostic imaging told us they were happy working at St Mary's treatment centre. There was good staff retention rate with a very low sickness rate.
- In diagnostic imaging, we observed a good approach to incident learning and sharing.
- In diagnostic imaging, although a small team, there was a good team culture with shared principles on the quality of the service delivered. There was evidence of good communication across all staff.

Public and staff engagement

- OPD staff regularly asked patients to complete satisfaction surveys on the quality of care and service they received. OPD staff used results of surveys to improve the service. Actions taken were displayed in waiting areas for patients to read.
- There was a Healthcare Heroes award scheme in place, whereby staff could nominate colleagues for an award. Monthly winners received a badge and certificate celebrating their achievement.
- We observed a newly engaged Patient Forum. A group of patients came together to discuss the treatment centre and its services to the community.

Innovation, improvement and sustainability

- Staff told us that they felt that a new system for monitoring performance, PISCES, had negatively affected patient care by reducing the length of appointments.
- Staff told us they were encouraged to improve services. The hospital encouraged innovation by offering quarterly awards for innovation for staff. The hospital management team collected ideas from staff. The hospital management team recognised staff whose ideas were collected and subsequently implemented some of these ideas.
- The diagnostic imaging department was planning to train a radiographer to discharge MIU patients directly if no abnormality is detected on the x-ray. The development of a discharging radiographer reflects that the managers are developing a dynamic approach.

Outstanding practice and areas for improvement

Outstanding practice

- In endoscopy, the latest Joint Advisory Group [JAG] accreditation report gave overall feedback that the treatment centre was an 'excellent' facility. JAG congratulated the leadership, environment, high quality service and well trained workforce. The JAG report recommended considering completing the JAG accreditation for training.
- In outpatients, patients were able to liaise in person with the appointment schedulers to arrange their next appointments prior to leaving the treatment centre. The schedulers were able to provide appointment options from which the patient selected a choice relevant to their life and preferences. This provided a personalised service for patients.

Areas for improvement

Action the provider MUST take to improve

Start here...

Action the provider SHOULD take to improve

The provider **should ensure**:

- That appropriate arrangements for monitoring and auditing the management and use of controlled drugs.
- That antibiotic liquid medicines given, include an expiry date once reconstituted.
- That appropriate actions are taken when it is identified that medicines have been stored outside of their recommended temperature range. .
- Health visitors are informed of children attending MIU.
- All relevant staff working in the MIU receive training in dementia and learning disability.
- Written literature is available in different formats, such as large print or braille, and languages other than English, and provide directions on how to access patient information.
- All staff are aware of the risk and hazard register records that relate to their ward/department areas.
- All areas have their own risk register or a dedicated section within the central risk register.
- A review of the walk-in service for x-ray patients is undertaken to improve waiting times and flow.
- The Diagnostic target is added to the risk register.
- A review of the walk in service for x-ray patients is undertaken to improve waiting times and flow
- Consider screening lead coats, used within fluoroscopy, annually in line with best practice guidelines.