Circle Nottingham Limited

The Nottingham NHS Treatment Centre

Quality Report

Nottingham NHS Treatment Centre
Queen's Medical Centre Campus
Lister Road
Nottingham
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Surgery	Outstanding
Outpatients and diagnostic imaging	Good
Termination of pregnancy	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Nottingham NHS treatment centre is run by Circle Nottingham Ltd which belongs to a group of companies owned by Circle. Independent NHS treatment centres provide services to NHS patients but are owned and run by organisations outside of the NHS. They have a contract with the NHS to treat NHS patients. The Nottingham centre opened in 2008 and is the largest independent treatment centre in Europe. Circle Nottingham Ltd was awarded the contract to provide services from the centre in July 2013 for five years. Although it predominantly provides services for NHS patients, the centre does provide services to patients who wish to pay privately for their treatment. The treatment centre is currently registered to provide services to children, however the centre was in the process of altering its registration and did not provide services to children at the time of our inspection.

The centre offers a variety of services including outpatients, surgery, termination of pregnancy and diagnostic tests. There were 60 outpatient consultation rooms, five operating theatres, three skin surgery theatres, four endoscopy rooms and dedicated diagnostic facilities such as scans and x-rays. In addition, the centre has an 11 bedded short stay ward for patients who have undergone surgery and need an inpatient stay.

The Nottingham NHS Treatment Centre was selected for a comprehensive inspection as part of the second wave of independent healthcare inspection. The inspection was conducted using the Care Quality Commissions new methodology. The inspection team inspected the following core services:

- Surgery
- Outpatients and diagnostic imaging
- Termination of pregnancy

We rated the Nottingham NHS Treatment Centre as “Good” overall but the termination of pregnancy service required improvement. The safety, caring and leadership in the surgical service were rated as "Outstanding."

Our key findings were as follows:

Care and Compassion

- Without exception staff were caring and compassionate. Patients reported very high levels of satisfaction with the care they received.
- We saw people being treated as individuals and staff spoke about patients in a kind and sensitive manner.

Cleanliness and inspection control

- The treatment centre had reported no incidence of MRSA, clostridium difficile (C.difficile) or Meticillin- sensitive Staphylococcus Aureus (MSSA) in the reporting period April 2013 to September 2014. MRSA, MSSA and C.difficile are infections that can cause harm to patients. MRSA is a type of bacterial infection that is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but it can be more easily treated. C.difficile is a bacterium that can affect the digestive system; it often affects people who have been given antibiotics.
- In all areas we observed staff to be complying with best practice with regard to infection prevention and control policies. Staff were observed to wash or apply gel to their hands between patients. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. The majority of staff were observed adhering to the dress code, which was to be bare below the elbow.
- Staff in operating theatres and endoscopy were observed to be following the correct technical procedures prior to undertaking sterile procedures in surgery.
- Most of the areas we visited were clean and well maintained. There were procedures for the management, storage and disposal of clinical waste, environmental cleanliness and the prevention of healthcare acquired infection guidance. However, in endoscopy we found storage within the decontamination areas made it difficult to ensure all areas were sufficiently clean. During our inspection we noticed the floor area under the sinks was stained and white

powder was visible. We discussed this with the nurse in charge who told us the metal racking stored within this area had probably not been moved to allow for effective cleaning of this area. We saw this had already been identified in the environmental hygiene audit in November 2014. We also saw the plans that were in place to improve the endoscopy area so this issue could be rectified. The work was due for completion by August 2015.

- Patients were given wound management advice following surgery. Verbal instructions were supported through the use of an information leaflet given to the patient when they were discharged. The information included details of what the patient should do if there were any wound complications after their discharge from the treatment centre.
- The cleaning of endoscopes met national decontamination standards for flexible endoscopes and we saw only appropriately trained staff were responsible for the decontamination of equipment.

Complaints

- There were quality monitoring structures in place to monitor any complaints. We found information throughout the centre that told patients how they could raise a concern, complaints or compliment. Staff had a good understanding of the complaints process and received regular feedback following complaints. The treatment centre analysed feedback and monitored themes. We saw evidence of changes to practice being undertaken in response to complaints and patient feedback. The treatment centre actively promoted the “Four Cs” process (complaints, concerns, comments and compliments). We saw these were reported quarterly as part of the treatment centre’s ‘quality quartet’ scorecard.
- We found areas in the complaints process that could be improved further because they were not consistently following their internal complaints policy. We found the treatment centre was not providing advice on how to obtain advocacy. The complaints leaflet that was being sent with the complaint acknowledgement letter was out of date and referred to an independent complaints advocacy service that was not longer in existence. We looked at a final response letter that contained no information about the Parliamentary and Health Service Ombudsman We also found not all complaints were being acknowledged within the required two day standard. We looked at one complaint where the final response deadline was not met and a letter sent to apologise for this and to extend the deadline was not sent until two weeks after the deadline had initially passed.

Staffing Levels

- Throughout our inspection both patients and staff told us they thought the treatment centre had sufficient staff. There were some concerns about the numbers of consultant dermatologists but this was being managed with the use of long term locums.
- Nurse staffing levels were in accordance with national guidance issued by the National Institute of Health and Clinical Excellence (NICE). There were escalations arrangements in place so that additional staff could be brought into an area should there be either a gap in the planned staffing or the level of dependency of the patients had increased.
- Where locum medical staff or bank or agency nursing staff were used a named individual would be requested from an agency approved by the treatment centre. This meant temporary staff were already familiar with the area in which they were working. The treatment centre had a robust system in place to ensure agency staff were appropriately inducted to the service. This included a dedicated induction programme and competency framework documentation for each gateway of the treatment centre.
- There was a Resident Medical Officer (RMO) based on the short stay unit who reported any changes in the patient’s condition to the consultants, and together with the nursing team provided 24 hour medical support to patients.

Mortality rates and outcomes for patients

- The treatment centre had reported no incidence of either day case or overnight inpatient mortality in the reporting period April 2013 to September 2014.
- There had been no unexpected patient deaths from April 2013 to December 2014. One had been reported to the CQC in January 2015. We were told a full investigation had been undertaken by the senior management team at the treatment centre and they were currently awaiting the outcome of a post mortem.

Summary of findings

- Transfers of care to a nearby trust had reduced since the opening of the short stay unit in April 2014. Information received prior to our inspection showed there had been two unplanned transfers of inpatients to other hospitals between April 2013 to December 2014. A senior manager told us this had been due to having no facilities for the provision of emergency care at the treatment centre. The transfer of these two patients was appropriate.
- There had been no unplanned readmissions within 29 days of discharge in the reporting period April 2013 to September 2014.
- Patient reported outcome measures (PROMS) for the period April 2013 to March 2014 indicated patient outcomes for groin hernia were worse than the England average. However for the reporting period April to June 2014 patient outcomes for groin hernia had improved and were in line with the England average. Outcomes for varicose veins surgery were similar to the England average.
- The treatment centre had started performing joint replacement procedures on knees in the six weeks preceding our inspection. Hip replacement surgery was due to commence at the end of February 2014. It was too early for any patient reported outcome data to be assessed at the time of the inspection.

Leadership

- There was good leadership throughout the treatment centre. Morale amongst individuals and in teams was extremely high. Staff felt very engaged and numerous staff told us how they felt listened too. There was a culture in the hospital where everyone was valued regardless of their position or grade.
- The treatment centre had a "Credo." This was displayed in the treatment centre and staff knew about it. The credo set out three main principles that underpinned their work. It puts patients at the centre of their care, empowers staff to do their best and pursues excellence. From our conversations with staff and patients we could see how the credo was put into practice.

We saw several areas of outstanding practice including:

- The treatment centre was piloting the implementation of a care certificate for healthcare assistants (HCA's) achieved through a HCA training programme which offered specialty training and skills development.
- The centre had an initiative called 'Stop the Line.' Any member of staff could stop activity if they felt patient safety may have been compromised. When "Stop the line" was triggered, there was immediate escalation of the issue and a resolution was developed immediately. All the staff we spoke with were enthusiastic about this initiative and were able to give examples of where they had used 'Stop the line.' The examples they gave demonstrated staff felt confident to use the process and most importantly that action was taken to respond to concerns. The treatment centre used a process called Swarm. Staff at different levels attended the swarm which was a meeting following a stop the line which was designed to assess the risk and put immediate control measures in place to reduce those risks. We saw evidence of this being used in practice.
- The treatment centre undertook a 28 day post-operative call to patients to monitor clinical outcome data that included surgical site infections. This patient self-reported data was shared with the commissioners of the service. Information received following our inspection indicated a decline in surgical site infections, with 13 reported in November 2014; nine reported in December 2014 and; three reported in January 2015.

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

Importantly, the provider must:

- Ensure medication administration records within the termination of pregnancy service are clearly legible and written in accordance with GMC guidance, "Good practice in prescribing and managing medicines and devices."
- Ensure the prescribing of Anti-D immunoglobulin medication within the termination of pregnancy service only takes place when it has been established that it is a clinically suitable treatment for the patient.

In addition the provider should:

Summary of findings

- Ensure complaints are managed in accordance with the treatment centre policy so that patients have up to date information about how they can access the support of complaints advocacy services.
- Ensure there is timely access to termination of pregnancy procedures, which should meet Department of Health required standard operating procedures (RSOP11 – access to timely abortions).
- Ensure the governance and leadership in the termination of pregnancy service is strengthened to ensure there is effective monitoring and response to the findings of audits.
- Ensure there is a system for checking the accuracy of HAS4 forms used in the termination of pregnancy service to ensure that accurate information is provided to the Department of Health.
- Ensure systems are developed so that sessional staff working in the termination of pregnancy service receive feedback and learning from incidents.
- Ensure a review of the risks associated with the use of the lifting and handling equipment within the imaging department takes place so that patients who have mobility difficulties can be safely assisted onto the imaging beds.
- Consider introducing team development initiatives within the termination of pregnancy service to enable cohesive working practices.
- Consider working with partner providers and commissioners of termination of pregnancy services to ensure the patients care pathway is one which meets required standards.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

The service was safe. We looked at the safety of three core services at the treatment centre. We rated the safety of the surgical service as outstanding and the remaining two services were good.

We found the process of investigations incidents, near misses and never events to be robust. We saw where actions had been identified and implemented as a result. All staff demonstrated a good awareness of the process for identifying and recording patient safety incidents including near misses.

Arrangements to minimise risks to patients were in place with measures to prevent falls and pressure ulcers and the early identification of patient risk during surgery. We saw elements of good infection prevention and control practice and clean clinical areas.

The centre had an initiative called 'Stop the Line.' Any member of staff could stop activity if they felt patient safety may have been compromised. When "Stop the line" was triggered, there was immediate escalation of the issue and a resolution was developed immediately. All the staff we spoke with were enthusiastic about this initiative and were able to give examples of where they had used 'Stop the line.' The examples they gave demonstrated staff felt confident to use the process and most importantly that action was taken to respond to concerns.

Throughout our inspection both patients and staff told us they thought the treatment centre had sufficient staff. There were some concerns about the numbers of consultant dermatologists but this was being managed with the use of long term locums.

Nurse staffing levels were in accordance with national guidance issued by the National Institute of Health and Clinical Excellence (NICE). There were escalation arrangements in place so that additional staff could be brought into an area should there be either a gap in the planned staffing or the level of dependency of the patients had increased.

The treatment centre had a robust system in place to ensure agency staff were appropriately inducted to the service. This included a dedicated induction programme and competency framework documentation for each gateway of the treatment centre.

Summary of findings

There was a Resident Medical Officer (RMO) based on the short stay unit who reported any changes in the patient's condition to the consultants, and together with the nursing team provided 24 hour medical support to patients.

Medicines were stored safely and we observed good practice where staff followed a safe medicines administration procedure.

Mandatory training compliance was mostly within the treatment centre target. Staff were aware of safeguarding procedures and had received training in safeguarding adults.

Patients' individual care records were accurate, complete, legible and up to date although in the termination of pregnancy service we found some records that contained inaccurate information. We saw where records and patient identifiable information was stored securely.

Are services effective?

Good

The surgery service was good but the termination of pregnancy service required improvement. We did not rate the effectiveness of the outpatient and diagnostic imaging service.

Procedures for assessing and delivering Anti-D injections for patients who were undergoing termination of pregnancy (TOP)were not robust. We found some patients did not have their blood tested before their surgery which posed a risk they would not get the required treatment.

The treatment centre did not meet a Department of Health requirement that all staff involved in pre-termination assessments were trained to diploma level in counselling.

Evidence based assessment, care and treatment was delivered in line with national guidance and quality standards by appropriately qualified staff. The endoscopy service had received national accreditation. Pain management was effective. Patients received pain relief suitable to them in a timely manner.

Surgical outcomes for patients were monitored and were either within or exceeding the national average.

The treatment centre had reported no incidence of either day case or overnight inpatient mortality in the reporting period April 2013 to September 2014. Transfers of care to a nearby trust had reduced since the opening of the short stay unit in April 2014. Information received prior to our inspection showed there had been two unplanned transfers of inpatients to other hospitals between April 2013 to December 2014. The transfer of these two patients was appropriate.

Summary of findings

There had been no unplanned readmissions within 29 days of discharge in the reporting period April 2013 to September 2014.

A multi-disciplinary team approach was evident across the treatment centre. We observed good multi-disciplinary working in all the areas we inspected and saw where there was a shared responsibility for care and treatment throughout the teams.

The percentage of staff undertaking appraisals from April 2014 to November 2014 averaged at 71%.

The term "practising privileges" refers to medical practitioners being granted the right to practise in a hospital. There were procedures in place for granting and reviewing practising privileges. We saw the treatment centre had implemented a robust system with a checklist and guidelines as to who was responsible for providing the information. Files had a checklist in and these had been audited. Where there were gaps in required information we could see where the treatment centre had emailed individuals to request information. Risk assessments of the impact of the lack of information were completed and the process had been identified on the treatment centre risk register.

The treatment centre was piloting the implementation of a care certificate for healthcare assistants (HCA) achieved through a HCA training programme. The programme provided HCA's with specialty training and an opportunity to develop their skills.

Are services caring?

Good

We found the caring in the surgical service was outstanding and good in the two other services.

All of the patients we spoke with were extremely positive about the quality of the care and treatment they were receiving. Throughout our inspection including our unannounced inspection we saw patients were consistently treated with the upmost compassion, dignity and respect. Patients were not rushed and they were treated as individuals. Staff were immensely proud of the care they delivered.

Are services responsive?

Good

Overall we found the responsiveness of the surgical and outpatient and diagnostic imaging services to be good but the responsiveness of the termination of pregnancy service required improvement

The treatment centre provided only part of the care pathway for women undergoing a termination of pregnancy (TOP) so some aspects of care delivery lay with other providers. Not all patients

received their TOP within national guidelines. it was not clear why this was not always being achieved although we did find evidence that if patients were near to a 14 week gestation there were systems to fast track procedures to limit the future risk to the patients health.

In the surgical and outpatients and diagnostic imaging services the access to care and treatment was either in line with or exceeded national guidance.

There were quality monitoring structures in place to monitor any complaints. We found information throughout the centre that told patients how they could raise a concern, complaints or compliment. Staff had a good understanding of the complaints process and received regular feedback following complaints. The treatment centre analysed feedback and monitored themes. We saw evidence of changes to practice being undertaken in response to complaints and patient feedback. The treatment centre actively promoted the "Four Cs" process (complaints, concerns, comments and compliments). We saw these were reported quarterly as part of the treatment centre's 'quality quartet' scorecard.

We found areas in the complaints process that could be improved further because they were not consistently following their internal complaints policy. We found the treatment centre was not providing advice on how to obtain advocacy. The complaints leaflet that was being sent with the complaint acknowledgement letter was out of date and referred to an independent complaints advocacy service that was not longer in existence. We looked at a final response letter that contained no information about the Parliamentary and Health Service Ombudsman We also found not all complaints were being acknowledged within the required two day standard. We looked at one complaint where the final response deadline was not met and a letter sent to apologise for this and to extend the deadline was not sent until two weeks after the deadline had initially passed.

Are services well-led?

Good

The surgery and outpatients and diagnostic imaging services were well led but the termination of pregnancy service required improvement.

We found the termination of pregnancy (TOP) service was managed in a fragmented manner and this meant the team was not cohesive and lacked a team identity. There were some systems in place to monitor the quality of the TOP service but there was insufficient action being taken to improve the quality of the service offered. Staff worked in isolation with there being a lack of opportunity to meet or develop the service.

Summary of findings

Morale amongst individuals and in teams was extremely high. Staff felt very engaged and numerous staff told us how they felt listened too. There was a culture in the hospital where everyone was valued regardless of their position or grade.

The treatment centre had a “Credo.” This was displayed in the treatment centre and staff knew about it. The credo set out three main principles that underpinned their work. It put patients at the centre of their care, empowers staff to do their best and pursues excellence. From our conversations with staff and patients we could see how the credo was put into practice. Staff were committed to the treatment centre’s objectives and values. The majority of staff we spoke to mentioned the treatment centre’s credo and valued it.

Morale was excellent with staff very positive about the organisation and their leaders.

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Outstanding ☆	The treatment centre had systems and processes in place to keep patients safe. Staff demonstrated a good awareness of the process for identifying and recording patient safety incidents. Where serious patient safety incidents had occurred we found the process of investigation to be robust with actions identified and implemented as a result. We saw arrangements were in place to minimise risks to patients with measures to prevent falls and pressure ulcers and, the early identification of patient risk during surgery. We saw elements of good infection prevention and control practice and clean clinical areas. Staffing within surgery was managed effectively at a local level to ensure there was no disruption to care delivery. We saw there was good access to senior clinicians when required. Staff were competent and suitably trained to deliver care in line with the Trust policies and procedures, national guidance and, NICE (National Institute for Health and Care Excellence) quality standards. Medicines were stored safely and we observed good practice where staff followed a safe medicines administration procedure. Patients' individual care records, including medication charts, were accurate, complete, legible and up to date. We saw where records and patient identifiable information was stored securely. Access to care and treatment and surgical outcomes for patients were mostly within, or exceeding, the national average. A multi-disciplinary team approach was evident across all of surgery the surgical services. We observed good multi-disciplinary working in all the areas we inspected and saw where there was a shared responsibility for care and treatment throughout the teams. All the patients we spoke with were extremely positive about the quality of the care and treatment they were receiving and with the approach of the staff. There were arrangements in place to monitor and improve quality and the morale of staff was extremely high.

Summary of findings

Outpatients and diagnostic imaging

Good

Overall we found that outpatients and diagnostic imaging departments were good.
We found that safety was good, incidents were reported and risks to patients were assessed. Infection control and cleanliness of the environment and equipment was of a good standard. There were no concerns around staffing levels across the outpatient services. Where there were challenges in medical and nursing staffing the treatment centre were able to plan and respond accordingly.
Appropriate systems were in place in diagnostic and imaging to measure quality and provide a safe and effective service but there was little evidence as to how effective the services were because the service was still new and had only been in place for six months at the time of our inspection.
The physical environment of the centre was modern and comfortable for patients. Waiting times for the majority of patients were better than both national and the internally set targets with patients waiting between eight and 11 weeks from referral to treatment. In diagnostics and imaging the wait for diagnostic tests was 18 days; which was better than the national guidelines.
Staff were caring and we saw many positive interactions between staff and patients. Patients were happy about their care and treatment.
Outpatients and diagnostic departments were well led. Staff were positive about working at the treatment centre and their leaders. Staff felt supported and involved in many aspects of the treatment centre and spoke of a positive culture which encouraged innovation and collaboration.

Termination of pregnancy

Requires improvement

Overall, we found termination of pregnancy services required improvement.
The termination of pregnancy service was fragmented and lacked cohesive leadership, team identity and systematic working practices. There were very limited opportunities for staff to meet and whilst there was some governance and monitoring of the service in place no one took responsibility for ensuring findings were used to improve the service. There was a shared care pathway with other providers. Work was being put in place to meet with other providers and improve communications and systems. Sometimes care and treatment wasn't

delivered effectively, particularly the taking of blood samples to establish if Anti-D treatment was required. As a result patients did not always receive the right treatment.

Although we found the staff were very caring and patients were positive about their experience, not all patients were offered counselling prior to their procedure. We also found not all staff involved in counselling of patients were trained to the level required in the required standard operating procedures.

Procedures did not always take place within the Department of Health required standard operating requirement of 10 working days. This was attributed to appointments being made by other providers. Referral to treatment times showed that 21% of procedures exceeded 10 working days. The reason for the delays was not recorded. Where patients were near to 14 weeks gestation there were systems to fast track procedures to limit the future risk to their health.

The Nottingham NHS Treatment Centre

Detailed findings

Services we looked at
Surgery; Outpatients and diagnostic imaging; Termination of pregnancy

Detailed findings

Contents

Background to The Nottingham NHS Treatment Centre

The Nottingham NHS Treatment Centre (ISTC) is run by Circle Nottingham Ltd which belongs to a group of companies owned by Circle. ISTC's provide services to NHS patients but are owned and run by organisations outside of the NHS. They have a contract with the NHS to treat NHS patients. The Nottingham ISTC opened in 2008 and is the largest independent treatment centre in Europe. Circle Nottingham was awarded the contract to provide services from the centre in July 2013 for five years. Although it predominantly provides services for NHS patients, the centre does provide services to patients who wish to pay privately for their treatment.

The centre offers a variety of services including outpatient, surgery and diagnostic tests. There were 60 outpatient consultation rooms, five operating theatres, three skin surgery theatres, four endoscopy rooms and dedicated diagnostic facilities such as scans and x-rays. In addition, the centre has an 11 bedded short stay ward for patients who have undergone surgery.

The Nottingham NHS Treatment Centre was selected for a comprehensive inspection as part of the second wave of independent healthcare inspection. The inspection was conducted using the Care Quality Commissions new methodology. The inspection team inspected the following core services:

- Surgery
- Outpatients and diagnostic imaging
- Termination of pregnancy.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

The team included CQC inspectors including a pharmacy inspector and a variety of specialists: a consultant dermatologist, a consultant surgeon, a radiographer, a registered nurse, a governance lead and an expert by experience.

Detailed findings

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 the centre, we reviewed a range of information we held about the hospital and spoke to the local clinical commissioning group. Patients were invited to contact CQC with their feedback. We carried out an announced inspection between 27 and 28 January 2015 and an unannounced inspection on 5 February 2015. We held focus groups with a range of staff in the hospital including nurses and medical staff. We also spoke with staff individually. We talked with patients and relatives and observed how people were being cared for and reviewed patients' records of their care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at the Nottingham NHS Treatment Centre.

Facts and data about The Nottingham NHS Treatment Centre

The Nottingham NHS Treatment Centre is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury
- Family planning services
- Termination of pregnancies

The centre operates under a Standard Acute Contract, providing outpatient, inpatient, diagnostic and therapeutic services. It is the only independent sector facility in the UK to offer teaching and research, including pre and post-graduate medical, nursing and Allied health professional (AHP) training.

The types of services offered at the centre include, dermatology, ophthalmology, termination of pregnancy, gynaecology, cardiology, cosmetic surgery, diabetes and endocrinology, ear nose and throat and audiology, gastroenterology, physiotherapy, rheumatology, orthopaedics and pain management.

The centre employed 12 medical consultants as well as having 163 consultant medical staff who had been granted practising privileges. Practising privileges is a term used when the person managing the hospital grants a consultant permission to practise as a medical practitioner at that hospital. The majority of the consultants working under practising privileges were directly employed in the neighbouring NHS trusts.

There were over 100 registered nurses employed by the centre as well as over 43 healthcare support workers.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	☆ Outstanding	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Termination of pregnancy	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Good	Good	Good	Good	Good	Good

Notes

Surgery

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

Information about the service

The Nottingham NHS treatment centre provided day surgery and in patient treatment for patients undergoing a variety of procedures, including pain management procedures, urological colorectal, gynaecological, ophthalmological, vascular, orthopaedic, podiatric, hepatobiliary and, skin surgery. Cosmetic surgery was not provided at this location.

Services for surgical patients were provided in outpatient's consultation sessions, the day surgery and short stay units and the endoscopy unit. There were five main operating theatres and three skin surgery theatres within the day surgery unit, four endoscopy rooms and an 11 bedded short stay ward. We visited all of these areas during our inspection.

During our inspection we spoke with 10 patients and two visiting relatives. We spoke with 32 staff from a range of various surgical related roles and held a group discussion with senior managers.

Summary of findings

The treatment centre had systems and processes in place to keep patients safe from avoidable harm. Staff demonstrated an excellent awareness of the process for identifying and recording patient safety incidents. Where serious patient safety incidents had occurred we found the process of investigation to be robust with actions identified and implemented as a result.

The service used a patient safety initiative called "Stop the Line." This was used by all staff, and had become custom and practice. It allowed staff to raise any concerns about the care and treatment being delivered to patients.

We saw arrangements were in place to minimise risks to patients with measures to prevent falls and pressure ulcers and, the early identification of patient risk during surgery. We saw elements of good infection prevention and control practice and clean clinical areas.

Staffing within surgery was managed effectively at a local level to ensure there was no disruption to care delivery. We saw there was good access to senior clinicians when required. Staff were competent and suitably trained to deliver care in line with the trust policies and procedures, national guidance and, NICE (National Institute for Health and Care Excellence) quality standards.

Medicines were stored safely and we observed good practice where staff followed a safe medicines administration procedure. Patients' individual care

Surgery

records, including medication charts, were accurate, complete, legible and up to date. We saw where records and patient identifiable information was stored securely.

Access to care and treatment and surgical outcomes for patients were mostly within, or exceeding, the national average.

A multi-disciplinary team approach was evident across all of surgery the surgical services. We observed good multi-disciplinary working in all the areas we inspected and saw where there was a shared responsibility for care and treatment throughout the teams. All the patients we spoke with were extremely positive about the quality of the care and treatment they were receiving and with the approach of the staff.

There were arrangements in place to monitor and improve quality and the morale of staff was extremely high.

Are surgery services safe?

Outstanding ☆

Overall we found surgical services at the treatment centre were safe.

The treatment centre had systems and processes in place to keep patients safe from avoidable harm. We found the process of investigations incidents, near misses and never events to be robust. We saw where actions had been identified and implemented as a result. All staff had demonstrated a good awareness of the process for identifying and recording patient safety incidents including near misses. The service used a patient safety initiative called "Stop the Line." This was used by all staff in the treatment centre if they had any concern the care and treatment being delivered to patients. We found the process was embedded throughout the treatment centre and had become custom and practice for staff.

Arrangements to minimise risks to patients were in place with measures to prevent falls and pressure ulcers and, the early identification of patient risk during surgery. We saw elements of good infection prevention and control practice and clean clinical areas.

Staffing within surgical services was managed effectively at a local level to ensure there was no disruption to care delivery. We saw there was good access to senior clinicians when required.

Medicines were stored safely and we observed good practice where staff followed a safe medicines administration procedure.

Mandatory training compliance was mostly within the treatment centre target.

Patients' individual care records were accurate, complete, legible and up to date. We saw where records and patient identifiable information was stored securely.

Incidents

- The treatment centre had reported two never events during the reporting period April 2013 to December 2014. Never events are classified as such because they are so serious that they should never happen. Both related to wrong site surgery and a serious incident

investigation and root cause analysis was undertaken on each never event. All staff we spoke with were aware of both incidents. Senior managers told us that following one of the never events the treatment centre had introduced a further stop before you start moment into the five steps to safer surgery process. The five steps to safer surgery is a safety checklist used in operating theatres to improve patient safety. 'Stop before you start' required operating theatre staff to complete a final check which included identification of site of surgery before it commenced.

- All the staff we spoke with were aware of and had access to the treatment centre's online incident reporting system. This allowed staff to report all actual incidents and near misses where patient safety may have been compromised. Staff gave examples of reportable incidents which included; a patient arriving for a procedure which had been cancelled and booked for another date.
- Across the treatment centre there was a clear focus on patient safety. The culture was one of staff being empowered to "Stop The Line." This empowered any member of staff to stop activity if they felt patient safety may have been compromised. It enabled immediate escalation and resolution of issues. All the staff we spoke with were enthusiastic about this initiative and were able to give examples of where they had used "Stop the line." Examples where stop the line had been used were when a nurse felt a vulnerable patient was not clear about the surgery they were due to have; where a machine malfunction was noted in the endoscopy unit, and where staffing was felt to be insufficient. The use of stop the line had become embedded and it was seen as custom and practice. without exception, staff at all levels told us they felt able to call "Stop the Line."

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Whilst the treatment centre did not use this tool they did monitor performance against the possible harms identified in the tool. For example incidents of falls, pressure ulcers, venous thromboembolism (VTE), hospital acquired infections and catheter associated urinary tract infections were monitored. Pressure ulcers are damage to the skin caused by pressure from being in the same position. VTE is a blood clot that forms in a vein, often in the leg and can cause harm to patients.
- The number of adult inpatient admissions, including privately funded patients, risk assessed for venous thromboembolism (VTE) was 95% or above for the reporting period July 2013 to September 2014. The treatment centre had reported no incidence of hospital acquired VTE or pulmonary embolism (PE) in the reporting period April 2013 to September 2014. A PE is a blood clot that forms in the lungs and can cause harm to patients.
- The Braden assessment tool was in use on the short stay unit to assess and categorise the risk of people developing a pressure ulcer. Braden is a risk assessment tool that helps identify patients who are at risk of developing pressure ulcers. No stage three or four pressure ulcers had been reported between April to December 2014.
- Falls screening had been implemented in day case, endoscopy and the short stay unit for over 65 year olds as part of the 2014/15 commissioning for quality and innovation (CQUIN). The CQUIN payments framework encourages care providers to share and continually improve how care is delivered. No slips, trips or falls with harm had been reported between April to December 2014.

Cleanliness, infection control and hygiene

- As part of the pre-operative process for patients admitted for surgery, all patients were screened for Methicillin-resistant Staphylococcus Aureus (MRSA). The treatment centre had reported no incidence of MRSA, clostridium difficile (C.difficile) or Meticillin- sensitive Staphylococcus Aureus (MSSA) in the reporting period April 2013 to September 2014. MRSA, MSSA and C.diff are infections that can cause harm to patients. MRSA is a type of bacterial infection that is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but it can be more easily treated. C.Difficile is a bacteria that can affect the digestive system, it often affects people who have been given antibiotics.
- Most of the areas we visited were clean and well maintained. There were procedures for the management, storage and disposal of clinical waste, environmental cleanliness and the prevention of healthcare acquired infection guidance. However, in

endoscopy we found storage within the decontamination areas made it difficult to ensure all areas were sufficiently clean. During our inspection we noticed the floor area under the sinks was stained and white powder was visible. We discussed this with the nurse in charge who told us the metal racking stored within this area had probably not been moved to allow for effective cleaning of this area. We saw this had already been identified in the environmental hygiene audit in November 2014. We also saw the plans that were in place to improve the endoscopy area so this issue could be rectified. The work was due for completion by August 2015.

- In all areas we observed staff to be complying with best practice with regard to infection prevention and control policies. Staff were observed to wash or apply gel to their hands between patients. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. All staff were observed adhering to the dress code, which was to be bare below the elbow.
- Staff in operating theatres and endoscopy were observed to be following the correct technical procedures prior to undertaking sterile procedures in surgery.
- The treatment centre undertook a 28 day post-operative call to patients to monitor clinical outcome data that included surgical site infections. This patient self-reported data was shared with the commissioners of the service. Information received following our inspection indicated a decline in surgical site infections, with 13 reported in November 2014; nine reported in December 2014 and; three reported in January 2015.
- Patients were given wound management advice following surgery. Verbal instructions were supported through the use of an information leaflet given to the patient when they were discharged. The information included details of what the patient should do if there were any wound complications after their discharge from the treatment centre.
- Infection control link nurses were available in all the areas we visited. Nursing staff told us the link nurses attended meetings and would feedback relevant information, including hand hygiene and environmental cleanliness audit results to their departments.
- The cleaning of endoscopes met national decontamination standards for flexible endoscopes and we saw only appropriately trained staff were responsible for the decontamination of equipment.

Environment and equipment

- We saw where the endoscopy unit mostly met national decontamination standards for flexible endoscopes. There was a designated and dedicated decontamination area with separate clean and dirty areas. However, on the day of our inspection both the clean and dirty areas appeared cluttered. Endoscope transportation cases were stored in these areas.
- The access to the decontamination area was compromised; there were no separate entry and exit points to enable one-way flow of equipment. Access to these areas was via a digital locked door and we saw staff had to negotiate the digital lock whilst carrying endoscope equipment.
- We discussed this with the nurse in charge, they told us the decontamination areas were not ideal and storage was a particular problem. Staff told us there were plans in place to address these issues with a re-design of the decontamination rooms. We saw the plans for this work and a proposed completion date of August 2015.
- The resuscitation equipment on the short stay unit, endoscopy and in the operating theatres was clean. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence that the equipment had been checked daily by staff and was safe and ready for use in an emergency.
- We observed all patient-care equipment to be clean and ready for use. Patient equipment had been routinely checked for safety with visible portable appliance testing (PAT) labels demonstrating when the equipment was next due for service.
- In the day case unit, anaesthetic equipment was checked by an operating department practitioner (ODP) before each list. Daily checks of all other patient-care equipment were carried out by nursing or ODP staff within the day case unit.

Medicines

- The treatment centre used a comprehensive prescription and medication administration record chart for patients which allowed for the safe

administration of medicines. Medicines interventions by a pharmacist were also recorded on the medication administration record charts to help guide staff in the safe administration of medicines.

- We looked at the medicine administration records for six patients across three clinical areas. We saw appropriate arrangements were in place for recording the ordering and administration of medicines. These records were clear and fully completed .The records showed people were taking their medicines when they needed them. If people were allergic to any medicines this was recorded on their medication administration record
- Medicines, including those requiring cool storage, were stored appropriately. Records showed that they were kept at the correct temperature, and so would be fit for use. We saw controlled drugs (medicines requiring extra security) were stored and managed appropriately. Emergency medicines were available for use, and there was evidence that these were regularly checked.
- There was a pharmacy top-up service for stock and other medicines ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- We reviewed the storage and administration of controlled drugs in the operating theatre department. We found them to be stored appropriately and records were accurately completed. Emergency medicines were available for use and there was evidence that these were regularly checked.

Records

- All the staff we spoke with were aware of their responsibilities around the safe keeping of records and confidentiality of patient information. Throughout the short stay unit, endoscopy and operating theatre department we saw where patient identifiable information was stored securely.
- We looked at nursing and medical records as part of our inspection. We noted that nursing records were well organised and information was easy to access. Records were complete and up to date. Each patient had a completed integrated care pathway booklet which included biographical details and contact details for next of kin.
- Records showed where staff had completed patient risk assessments. These included risk assessments for pressure ulcers, falls, bed safety and malnutrition. All the risk assessments completed followed a nationally recognised tool.
- We saw where additional information stored within the nursing records related to the care of the individual patients. Examples included a catheter care plan and, pre-assessment checklist.
- Medical records contained well documented information on admission and following daily reviews. We saw evidence of multi-disciplinary input from allied health professionals and specialist nurses.

Safeguarding

- The treatment centre had a named nurse, named doctor and executive lead for safeguarding. All staff had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns.
- Safeguarding adults (level two) training compliance rates were reported to be 83% (33 out of 40 staff) in endoscopy; 91% (59 out of 65 staff) in the day case unit and, 92% (12 out of 13 staff) on the short stay unit.

Mandatory training

- Staff told us they were up to date with mandatory training. Nursing and medical staff we spoke with reported having good access to mandatory training and described being able to access training 'in-house' and, via an online learning service.
- The treatment centre target for staff compliance with mandatory training was 80%. Information received from the treatment centre following our inspection showed the overall training compliance rates within the day case unit and endoscopy to be in-line with this target and, on the short stay unit to be 72%.

Assessing and responding to patient risk

- We saw where anaesthetists were expected to calculate the patients ASA grade as part of the referral process for general anaesthetic. The ASA physical status classification system is a system used for assessing the fitness of cases before surgery. Anaesthetic records we reviewed showed where the ASA grade had been calculated in 16 out of 17 cases.
- Staff on the short stay unit used an early warning system to record routine physiological observations such as

blood pressure, temperature and heart rate and monitor a patient's clinical condition. This was used as part of a "track-and-trigger" system where an increasing score triggered an escalated response. The response varied from increasing the frequency of the patient's observations up to urgent review by the resident medical officer or the patient's consultant. All the nursing staff we spoke with felt confident about contacting the patient's consultant by telephone and all said the consultant would attend the patient in a timely manner. One nurse told us when they had contacted the consultant at home they had attended within half an hour.

- In the nursing records we reviewed we saw staff were following National Institute for Health and Care Excellence (NICE) guidance CG50; "Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital." Observation records were complete and we saw where escalation had taken place appropriately.
- Staff followed the five steps to safer surgery in the operating theatre department and endoscopy. Staff used a document based on the World Health organisation (WHO) safety procedures; 'WHO surgical safety checklist – No Stop No Op!' to ensure each stage of the patients journey was managed safely. Medical records we reviewed showed the WHO checklist had been completed in 16 out of 17 cases. On the endoscopy unit we observed staff adhering to the five steps to safer surgery.
- The treatment centre carried out monthly audits of compliance with the WHO safety surgical safety checklist. compliance with the sign in, time out and sign out was good, with scores of over 97%.
- Nursing staff within the recovery department of the day case unit had good access to medical support in the event of a patient's condition deteriorating. Staff reported timely access to the on-site resident medical officer and the anaesthetist should a patient require immediate medical input. On the day case unit staff used the 'situation, background, assessment, recommendation' (SBAR) communication tool. This enabled staff to communicate critical information that required immediate attention and action in a structured way.
- Integrated care pathways were in use throughout the short stay, day case and endoscopy units. These were used to manage, monitor and record the patients care at the treatment centre. We saw pathways completed for local and general anaesthetic procedures.

Nursing staffing

- The treatment centre had 11 in-patient beds. Senior managers told us staffing reflected the NICE guidelines on staffing levels and exceeded the recommendations. Nursing staff we spoke with reported having enough staff on duty to deliver care effectively. Patients we spoke with were all consistently positive about the number of nursing staff available and felt there were sufficient staff to meet their needs.
- The establishment for nurse staffing across all inpatient departments at the hospital which included day case, endoscopy and, the short stay unit was 15.3 whole time equivalents (WTE). This included a nurse manager, a nurse team leader, registered nurses and care assistants. The ratio of nurse manager to nurse team leader was 1 to 1.6, the ratio of nurse team leader to other nurse roles was approximately 1 to 9.6 and, the ratio of other nurse roles to care assistants was approximately 1 to 0.9.
- The rate of agency staff use for the day case department steadily increased over the reporting period June 2013 to November 2014 reaching a peak of 17% in October 2014. It fell to 9% in November. Agency staff use for the endoscopy department was between 0% and 3% over the same reporting period. For the short stay unit, the rate of agency staff use was nil up to October 2014 and 12% for November 2014. Nursing staff on the short stay unit told us the unit opening times had been extended in November 2014 and agency use had increased to reflect this.
- Nursing staff in all areas told us they used temporary staff on an ad hoc basis. Where temporary staff were used a 'named individual' would be requested from an agency approved by the treatment centre. This meant temporary staff were already familiar with the area in which they were working. The treatment centre had a robust system in place to ensure agency staff were appropriately inducted to the service. This included a dedicated induction programme and competency framework documentation for each gateway of the treatment centre.

Theatre staffing

Surgery

- Establishments across theatres had been reviewed by the treatment centre lead nurse. Where national guidance existed such as in colposcopy and day surgery the guidance had been reviewed and was reflected in the establishments for the area. The establishment review focussed on ensuring that the staffing levels across the treatment centre reflected the changing needs of the service.
- The establishment for nurse staffing across all theatre departments was 76.5 whole time equivalents. This included nurse managers, team leaders and registered nurses. Across the theatre departments the ratio of nurse manager to nurse team leader was 1 to 2.87 and, the ratio of nurse team leader to other nurses was 1 to 5.3. All of the staff we spoke with felt there were sufficient staff to meet patient's needs. Where staffing levels were identified as being insufficient, the lead nurse would obtain additional staff through an approved agency or from other areas within the treatment centre. Nursing staff told us they would use the "Stop The Line," process if they felt staffing levels compromised care.

Surgical staffing

- The Resident Medical Officers(RMO) underwent a recruitment process before they commenced employment. This involved checking their suitability to work at the centre, checks on their qualifications as well as references and disclosure and barring checking. All of the RMO's underwent the treatment centre induction programme. There were systems in place to check the RMO's stayed up to date with mandatory training. The RMO's participated in monthly resuscitation scenarios.
- There was a Resident Medical Officer (RMO), based on the short stay unit, who reported any changes in the patient's condition to the consultants, and together with the nursing team provided 24 hour medical support to patients.
- The RMO attended nurse handover on the short stay unit and was aware of the number of patients in the hospital and any patients who may require additional medical support.
- We were told that patients' individual consultants would attend the hospital if a patient review was requested by the RMO or any of the nurses.
- The RMO underwent an induction programme. there

Major incident awareness and training

- The treatment centre had roles and responsibilities in the nearby trust's major incident policy. Senior managers told us, if a major incident was declared in the locality the nearby trust would inform the treatment centre of their role. This had occurred recently in January 2014 when, the nearby trust had declared an 'internal incident' due to extreme pressure on the emergency department.
- Staff working in the day case unit had been involved in rehearsing major incident scenarios. These included simulated bomb and fire alerts.
- The treatment centre had business continuity plans in place. Staff in endoscopy told us of an incident before our inspection where they had experienced a power failure as a result of construction work occurring outside the building. At the time of the incident staff had initiated "Stop the line," until the failure was resolved.

Are surgery services effective?

Good

Surgical services at the treatment centre were effective. Evidence based assessment, care and treatment was delivered in line with national guidance and quality standards by appropriately qualified staff.

Pain management was effective. Patients received pain relief suitable to them in a timely manner. Surgical outcomes for patients were monitored and were either within or exceeding the national average.

A multi-disciplinary team approach was evident across all of surgery. We observed good multi-disciplinary working in all the areas we inspected and saw where there was a shared responsibility for care and treatment throughout the teams.

Evidence-based care and treatment

- In 2012 the treatment centre had been awarded accreditation by the Joint Advisory Group (JAG) on gastrointestinal endoscopy. This is a national award given to endoscopy departments that reach a gold standard in various aspects of their service, including patient experience, clinical quality, workforce and training. Following successful completion of the annual report card in October 2014 the treatment centre was

JAG accredited for 2015. JAG visits to units are held every five years, but accreditation is issued annually following successful completion of the annual report card.

- The delivery of surgical care in the day case unit was consistent with the British Association of Day Surgery (BADS).
- Patient needs were assessed and care and treatment was delivered in line with National Institute of Health and Care Excellence (NICE) quality standards. For example clinical staff followed guidance relating to falls assessment and prevention, pressure ulcers, and venous thromboembolism.
- Information received prior to our inspection showed all 2013/14 commissioning for quality and innovation (CQUIN) requirements had been met by the treatment centre. These included; dementia training and operating theatre safety. CQUINS had been agreed with commissioners for 2014/15.
- Local audit activity in endoscopy included an audit of patient documentation. We saw audit results from March 2014. Recommendations from this audit had included a reminder to all staff to ensure documentation was completed in accordance with the nursing and midwifery council (NMC) record keeping guidance. The NMC is the professional regulator of nurses and midwives in the UK.

Pain relief

- A patient information leaflet "Pain relief after surgery," was available to patients. The leaflet followed national guidance.
- Staff on the short stay unit, endoscopy and the day case unit were required to use a pain assessment score to assess the comfort of patients both as part of their routine observations and at a suitable interval of time after giving pain relief. Nursing records we checked demonstrated where staff were identifying the patient's level of pain and evaluating the effects of pain relief on a consistent basis.

Nutrition and hydration

- We saw patients were screened for malnutrition and the risk of malnutrition on admission to the treatment centre using an adapted Malnutrition Universal Screening Tool (MUST).
- Staff followed guidance on fasting prior to surgery which was based on best practice guidance. This allowed healthy adults to eat up to six hours prior to planned surgery and drink water two hours before.
- All the patients we spoke with commented positively on the choice of food available.

Patient outcomes

- The treatment centre had reported no incidence of either day case or overnight inpatient mortality in the reporting period April 2013 to September 2014.
- There had been no unexpected patient deaths from April 2013 to December 2014. One had been reported to the CQC in January 2015. We were told a full investigation had been undertaken by the senior management team at the treatment centre and they were currently awaiting the outcome of a post mortem.
- Transfers of care to a nearby trust had reduced since the opening of the short stay unit in April 2014. Information received prior to our inspection showed there had been two unplanned transfers of inpatients to other hospitals between April 2013 to December 2014. A senior manager told us this had been due to having no facilities for the provision of emergency care at the treatment centre. The transfer of these two patients was appropriate.
- There had been no unplanned readmissions within 29 days of discharge in the reporting period April 2013 to September 2014.
- Patient reported outcome measures (PROMS) for the period April 2014 to September 2014 indicated patient outcomes for groin hernia were similar to expected compared with the England average. Outcomes for varicose veins surgery were also similar to the England average.

- The treatment centre had started performing joint replacement procedures on knees in the six weeks preceding our inspection. Hip replacement surgery was due to commence at the end of February 2014. It was too early for any patient reported outcome data to be assessed at the time of the inspection.
- The treatment centre completed an audit of complete excision rates for basal cell carcinoma in July 2014. The audit reviewed and compared complete excision rates between different clinical groups of clinicians across the surrounding region. Results showed out of a total of 189 excisions, excision was complete in 94% of all cases. We saw where there was a variation in incomplete excision

rates amongst the clinical groups. Incomplete excision rates for those clinicians practicing outside the treatment centre were higher than those working in the dermatology department.

- The British Society of Gastroenterologists (BSG) set a standard of 90% for successful caecal intubation during colonoscopy procedures. The caecal intubation rate (CIR) is a marker of full colonoscopy and when supported by the other performance measures it contributes to a high quality patient-centred outcome. Colonoscopy performance data for the reporting period August 2013 to May 2014 indicated six out of 21 endoscopists had achieved a standard of between 85 and 90% and 10 out of 21 endoscopists had exceeded this standard. Clinical outcomes in endoscopy were reviewed by the lead clinician every six months. Clinical outcomes would be reviewed against joint advisory group (JAG) standards and any variation would be discussed with the individual clinician.

Competent staff

- The percentage of staff undertaking appraisals from April 2014 to November 2014 averaged at 71%. Within surgery we saw appraisal completion rates of 50% on the short stay unit but this was due to this being a newly opened unit. The managers were working to improve the rates within the short stay and day case units where rates were 64% and 74% respectively.
- For consultants with practising privileges, the treatment centre kept a record of their employing NHS Trust together with the responsible officers (RO) name. The term "practising privileges" refers to medical practitioners being granted the right to practise in a hospital.
- Where human resource issues had arisen, the Clinical Chair of the treatment centre would contact the RO to discuss the issues. The human resource team at the employing NHS trust would also be contacted. The treatment centre supplied information about patient outcomes and patient feedback to the doctor for General Medical Council (GMC) revalidation purposes.
- There were procedures in place for granting and reviewing practising privileges. We saw the treatment centre had implemented a robust system with a checklist and guidelines as to who was responsible for providing the information. Files had a checklist in and these had been audited. Where there were gaps in required information we could see where the treatment centre had emailed individuals to request information. Risk assessments of the impact of the lack of information were completed and the process had been identified on the treatment centre risk register.
- The proportion of staff whose professional registration status had been verified post-application check was 100% since November 2014. This included nurses and doctors employed by the treatment centre and, those doctors working under practising privileges.
- The treatment centre was piloting the implementation of a care certificate for healthcare assistants (HCA) achieved through a HCA training programme. The programme provided HCA's with specialty training and an opportunity to develop their skills.
- Nursing staff new to the pre-assessment area of the day surgery unit were required to complete a six-week professional development programme in order for them to function effectively within the department. Staff were also able to access learning modules through the British Association of Day Surgery (BADS) organisation. One nurse we spoke with told us they had recently attended a two-day BADS conference which included pre-assessment scenarios, workshops and an update on national guidelines.
- Staff in the endoscopy unit were appropriately trained. We saw where the service was supported by a lead consultant and three nurse endoscopists. We were told a fourth nurse endoscopist was currently in training. Where there were doctors in training these were allocated a named supervisor and endoscopy lists would be reduced to reflect their training needs.
- Staff within endoscopy accessed the joint advisory group (JAG) endoscopy training system to identify and complete endoscopic training courses appropriate to their needs. An electronic portfolio was maintained by staff to record endoscopic experience and demonstrate performance, progression and competencies for submission to the JAG for certification.

Multidisciplinary working

- A multi-disciplinary team (MDT) approach was evident across all of the areas we visited and was notably inclusive of managers and team leaders.
- Safety huddles (brief face to face meetings) took place daily in the operating theatre department and endoscopy. All staff on the endoscopy unit were involved and included the consultant, nurse

endoscopists, staff nurses and health care assistants. Nursing staff told us safety huddles were an opportunity to discuss any safety issues in addition to the scheduled list for the shift.
- Multidisciplinary team working was evident within the pain team which consisted of four consultants; two nurse specialists, two specialist physiotherapists, a bio psychosocial occupational therapist and a professor of pharmacy.

Seven-day services

- The treatment centre had five operating theatres open five days a week with two sessions per day. In addition to this, two of the theatres provided an additional theatre session on a Saturday and one theatre offered a further two operating sessions on a Sunday. Operating times ran from 08.30 until 21.00hrs each day.
- There were an additional three skin surgery theatres operating from 08.00 to 17.00 five days a week. A further session was available on a Saturday on an as required basis.
- The endoscopy unit had four treatment rooms and delivered a service five days a week with an additional service every second Saturday. Out of hours support in endoscopy was not available from this location. Routinely, three sessions were offered Monday to Thursday and an all-day session on a Friday.
- Consultants practising within the treatment centre were responsible under practising privileges for care of their patients 24/7. This covered planned and unplanned admissions to the short stay unit.
- There was a resident medical officer (RMO) within the treatment centre 24 hours a day with immediate telephone access to the responsible consultant.
- Pharmacy services were provided for extended hours in the week and were available on Saturdays from January 2015. For urgent and emergency pharmacy issues there was access to an on call pharmacist.
- Physiotherapy services were provided by an independent provider and provided inpatient cover Monday to Friday and at weekends as dictated by patient need.
- The treatment centre was also supported by an on call Lead Nurse, on call Senior Manager, an on call engineer and Information Technology support.

Access to information

- The treatment centre had a standard operating procedure for the admission of patients to the short stay unit who were undergoing a surgical procedure. This meant there was a standard system in place for each patient being admitted to the unit.
- Patient information leaflets, following national guidance, were available for those surgical procedures commonly undertaken at the treatment centre. These leaflets were downloaded and printed as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they were aware of the treatment centres policy on consent. Consent was sought from patients prior to the delivery of treatment; patients we spoke with told us that they felt involved in decisions about their care. We looked at 15 consent forms during our inspection; consent was appropriately obtained in all of the forms we reviewed.
- Within endoscopy registered nurses were trained to obtain patient consent prior to a procedure. We looked at seven consent forms that had been completed by a nurse. All the forms were legible and complete. Risks of the procedure had been clearly identified. We saw where a copy of the consent form was given to the patient and a copy filed in the medical notes.
- Most staff we spoke with demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 and knew what to do where patients lacked the mental capacity to give consent for themselves. The treatment centre target for compliance with training around the mental capacity act was 80%. Information received from the treatment centre following our inspection showed the overall training compliance rates within the day case unit and endoscopy to be in-line with this target.

Are surgery services caring?

Outstanding ☆

The care of patients in the surgical service was outstanding. Patients were extremely positive about the quality of the care and treatment they were receiving. Throughout the

service we saw how patients were consistently treated with the upmost compassion, dignity and respect. Patients were not rushed and they were treated as individuals. The caring that we saw exceeded our expectations.

Staff were exceptionally proud of the care they delivered and spoke about patients with respect and compassion. We saw care was very responsive to patient's needs.

Compassionate care

- Patients were consistently positive about their experience at the treatment centre. Patients told us they were treated with dignity and staff were caring. Many of the patients we spoke with told us their expectations had been exceeded.
- We observed staff treating patients respectfully and with dignity. All staff were welcoming towards patients and supported them in a professional and sensitive manner.
- On the short stay unit nursing staff performed 'hourly rounding'. Hourly rounding is a process of interacting with patients on a planned, regular basis to anticipate their fundamental care needs.
- In day case recovery we observed exceptionally positive interactions between the nurses and patients. Patients were cared for on a one to one nurse patient ratio. We observed nurses to be attentive, caring and reactive to the patient's clinical condition. One patient had been in recovery longer than would usually be expected due to difficulties controlling their pain. We saw the nurse constantly offering reassurance and checking if the patient's level of pain had reduced following administration of pain relief. The care we observed patients receive was exceptionally responsive to their needs. Staff spoke about the patients they cared for in a very compassionate way and many of the staff told us how they cared for their patients like they were their own family.
- Nurses and other staff were really proud of the care they delivered. Patients consistently told us how well they had been cared for. Patients frequently compared their experience with their experience of care in other settings. They told us they were much more satisfied with the treatment centre care.

Understanding and involvement of patients and those close to them

- Throughout the short stay unit, day case and endoscopy unit we observed staff checking the patients understanding of their procedures before treatment commenced and during any interventions. Staff took their time, patients were not rushed and we saw patients were treated as individuals.

Emotional support

- We asked staff about the emotional support available to patients who may have received 'bad news'. Staff told us of a multi-faith worship room and the 'sunflower' rooms. These were dedicated quiet rooms situated in various locations throughout the treatment centre. Patients and staff also had access to nurse specialists to provide more specialist support for patients.
- On the endoscopy unit the nursing team were being trained in how to break bad news so it was done in the most supportive and sensitive way possible.

Are surgery services responsive?

Good

Surgical services at the treatment centre were responsive to patient's needs. Access to care and treatment was monitored and was in line with or exceeded the national average. Staff had a good understanding of the complaints process and received regular feedback following complaints.

Service planning and delivery to meet the needs of local people

- The treatment centre delivered services to patients who were prisoners. We found the treatment centre provided a service to meet the specific needs of people who were detained.
- The service provided the service it was commissioned for and could adapt to meet the needs of patients as needed. For example, the treatment centre had taken on additional work from another NHS organisation who was struggling to meet waiting time targets. Additional clinics were put on as needed to ensure the service was responsive to demand.
- There were no mixed sex breaches at the treatment centre.

Access and flow

Surgery

- The Referral to Treatment (RTT) operational standard for the treatment centre was that 90% of admitted patients should start consultant-led treatment within 18 weeks of referral. From April to September 2014 the treatment centre had exceeded this target.
- In order to ensure that patients were appropriately referred for surgery the treatment centre had referral criteria for those patients requiring general anaesthesia as a day case. This included consideration of an admission to the short stay unit (SSU) if required.
- Registered nurses trained in pre-operative assessment carried out pre-operative assessments of patients. Upon arrival patients were asked by reception staff if they wished to stay for their pre-operative assessment and were given an approximate waiting time. Alternatively they could choose to return at a later date that was more convenient to them.
- Between October 2013 and September 2014 the treatment centre had 27,524 visits to the operating theatre with most carried out as a day case procedure. There were no unplanned returns to theatre during this reporting period.
- We observed staff informing patients of the approximate time of their treatment. Within the day surgery unit this information was delivered face-to-face and on a television screen. On the day of our inspection waiting times were ten to 15 minutes for patients waiting to be seen in the pre-assessment clinic. In endoscopy we saw where there were no delays to treatment times. Staff told us where delays were identified these would be displayed on a television screen and the reception staff would speak to waiting patients.
- Patients were admitted to endoscopy via outpatient clinics or by their GP. At the time of our inspection pre-assessment was not carried out in endoscopy. Nursing staff told us this was due to nursing staff vacancies within the unit. Whilst we saw no evidence of any negative impact on patient care, staff told us it had increased the number of telephone enquiries they were receiving.
- We saw where patients had timely access to endoscopy with patients with a suspected cancer diagnosis being seen within the national timescale for urgent referrals of two weeks. All other patients were seen within 17 days of their referral.
- Information was given to patients when they were discharged from the treatment centre. This included details of who the patient should contact if they had any concerns following discharge. One patient we spoke with was waiting to be discharged from the day case unit. They told us they had been given information from the nurse and the anaesthetist.

Meeting people's individual needs

- The service had a policy for using interpreter services. We reviewed the policy and found it was in date and suitable for purpose it also took account that people may request an interpreter of a certain sex.
- There was an information leaflet for patients admitted to the short stay unit. This explained what would happen to the patient before, during and after their procedure and included who the patient should contact if they required the leaflet in braille, audiotape, large print or another language.
- Where patients, attending the treatment centre had been identified as having specific needs these were individually addressed. For example, in day case less mobile patients were asked if they wished to be cared for on a trolley or recliner chair in order to be more comfortable. Those patients living with dementia or a learning disability were given the option of their carer being present for the most part of their treatment.

Learning from complaints and concerns

- The Clinical Governance and Risk Committee reviewed the handling of complaints, compliments and themes. The committee met monthly and reported to the board.
- Complaints leaflets were available in all gateways. These encouraged patients to talk to staff if they had a concern and also highlighted the formal complaint process. However, we noted that information contained within the leaflet was out of date. The patient advocacy service was incorrectly titled and the contact phone number for the advocacy service was no longer in service.
- Staff would speak to anyone raising a complaint at the time they raised it. Lead nurses and operational managers were also available to talk to anyone with a concern or complaint. The aim was to try and resolve the problem or complaint at the time it was raised.
- Complaints were discussed at clinical unit and team meetings and learning points were identified.
- Complaint themes and key learning were reviewed at the clinical governance and risk committee and disseminated to the wider treatment centre.

Surgery

- During our inspection we saw 'you said; we did' boards displayed in the clinical areas. These identified the changes that had been made from complaints.
- The treatment centre actively promoted the "Four Cs" process (complaints, concerns, comments and compliments). We saw these were reported quarterly as part of the treatment centre's 'quality quartet' scorecard. Staff told us the four Cs would also be discussed at the staff partnership sessions.

Are surgery services well-led?

Outstanding ☆

Staff were committed to the treatment centre's objectives and values. The majority of staff we spoke to mentioned the treatment centre's credo and knew how it linked to the treatment centres objectives and their day to day work.

Morale was excellent with staff very positive about the organisation and their leaders. staff engagement was high. Staff felt listened too and supported.

Vision and strategy for this service

- The treatment centre had their own "Credo." This described their purpose, parameters and principles for healthcare provision. We saw where this was clearly visible throughout the areas we visited. All of the staff we spoke to were able to refer to the credo and explain how their role fitted in with it.
- We saw the corporate vision and values displayed on gateway notice boards.

Governance, risk management and quality measurement

- Senior managers of the endoscopy unit met weekly to discuss the departments performance. We reviewed minutes from these meetings and saw where there was a standing agenda that included discussions around; incidents, risks, and patient experience
- Each of the individual departments at the treatment centre produced a performance scorecard on a three-monthly basis. The scorecard was discussed by senior managers at board level in addition to being discussed at a local level through the partnership sessions that were held within individual clinical units. All the staff we spoke with were aware of the scorecard relevant to where they were working and gave examples of the content. This included; patient experience; staff performance, including sickness, vacancies and, training; clinical outcomes and; the financial position of the individual unit.
- There was a risk register in place for the treatment centre. We saw this was up to date and risks were mitigated. Risks had a named lead who was responsible for the actions. The risk register was monitored through the clinical governance and risk management committee.
- There was a monthly clinical governance and risk management committee which was responsible for monitoring the quality of the services across the hospital. Each of the gateways had clinical governance meetings and they reported into the overarching governance group. The leadership team had oversight of key performance indicators. There were standing agenda items such as number of patient harms, incidents and complaints.
- There was a positive working relationship with the commissioners of the service. The commissioners reviewed performance of the treatment centre on an on-going basis. senior staff worked with the commissioners to ensure the needs of patients were met. For example, the treatment centre had taken on work from other providers at short notice in order to help pressures within the NHS system.

Leadership of service

- The treatment centre was well led. Staff spoke highly of the leadership within the centre.
- The treatment centre had a lead nurse and medical director who provided professional leadership for the clinical staff. both of these executive leads were very visible and staff found them approachable. They worked together and had a common purpose.
- All the staff we spoke with, from a range of various surgical related roles, described senior managers as approachable, visible and who adopted an 'open door policy.'
- Lead nurses were available in all the areas and were visible to staff.

Culture within the service

- Across all the areas we inspected staff consistently told us of their commitment to providing safe and caring services. Overall staff spoke positively about morale and the care they delivered.

Surgery

- Staff felt listened to, valued and involved in changes within the treatment centre. Staff told us they were proud to work at the treatment centre.
- We were struck by how positive staff were about working at the treatment centre. There was an open culture and non-medical staff felt equal to medical staff. They felt valued and respected.
- The treatment centre had a policy in place to provide staff with fresh fruit every day. Staff could also access a massage whilst at work. These benefits helped staff feel cared for and valued.
- Many staff referred to feeling lucky they worked there. We noted at more than one of the nursing staff focus groups we held that comments were made about staff feeling a sense of guilt for working at the treatment centre. they perceived their working conditions were far better than the experience of colleagues working in other organisations. We asked them more questions about this and the reasons given were because they felt valued and listened to by the organisation.
- Staff consistently told us they had enough staff to deliver good care, they also felt this created a calm atmosphere which benefited both staff and patients.

Public and staff engagement

- Partnership sessions were held within clinical units and open to all staff involved in the patient pathway. The purpose of the sessions was to improve competence and educate staff, enable discussions of any issues that had arisen, and provide the opportunity to develop realistic and effective solutions. All staff we spoke with across endoscopy and the day case and short stay units had attended these partnership sessions and valued them.
- An annual staff survey was conducted in endoscopy as part of their JAG accreditation process. We saw the results of the staff survey for April 2014 and how the managers have taken action to respond to feedback in the staff survey.

Innovation, improvement and sustainability

- The treatment centre was piloting the implementation of a care certificate for healthcare assistants (HCA's) achieved through a HCA training programme which offered specialty training and skills development.

Outpatients and diagnostic imaging

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

Information about the service

The outpatients and diagnostic imaging services at Nottingham NHS treatment centre covered a wide range of specialties including dermatology, orthopaedic, ophthalmology, vascular, respiratory, and gastroenterology. Some clinics were also held out in the community. The diagnostic and imaging department carried out routine x-rays as well as more complex tests such MRI and CT scans.

The centre was open 07:00 to 21:00 Monday to Friday as well as having ad hoc clinics on Saturdays for those clinics in demand. Patients were referred by their GP, through consultant's private practice or as self-referrals.

NHS services were commissioned by local clinical commissioning groups. Diagnostic and imaging services had recently moved from being provided by a Service Level Agreement (SLA) with an NHS trust to a new diagnostic and imaging service at the treatment centre. All diagnostic and imaging services were now provided by the treatment centre except for ultrasound and Dexa scanning which were still provided under an SLA with the local NHS trust.

The clinics at the treatment centre were grouped and based in 'gateways' lettered A to I. During our inspection we spoke to 63 members of staff including diagnostic and imaging staff, consultants, nursing and non-nursing staff. We looked at five staff training and induction records. We observed care and looked at 18 patient medical records. We spoke to 28 patients and seven relatives.

Summary of findings

Overall we found that outpatients and diagnostic imaging departments were good.

We found that safety was good, incidents were reported and risks to patients were assessed. Infection control and cleanliness of the environment and equipment was of a good standard. There were no concerns around staffing levels across the outpatient services. Where there were challenges in medical and nursing staffing the treatment centre were able to plan and respond accordingly.

Appropriate systems were in place in diagnostic and imaging to measure quality and provide a safe and effective service but there was little evidence as to how effective the services were because the service was still new and had only been in place for six months at the time of our inspection.

The physical environment of the centre was modern and comfortable for patients. Waiting times for the majority of patients were better than both national and the internally set targets. Patients waited between eight and 11 weeks from referral to treatment. In diagnostics and imaging the wait for diagnostic tests was 18 days; which was better than the national guidelines.

Patient satisfaction was very high, but we found that parking was the main concern for patients due to tram works taking place outside the treatment centre. The lack of parking and disruption meant that patients were taking longer to get to their appointment.

Outpatients and diagnostic imaging

Staff were caring and we saw many positive interactions between staff and patients. Patients were happy about their care and treatment at the treatment centre.

Outpatients and diagnostic departments were well led. Staff were positive about working at the treatment centre and morale was very high. Staff felt supported and involved in many aspects of the treatment centre. They consistently told us about a positive culture which encouraged innovation and collaboration.

Are outpatients and diagnostic imaging services safe?

Good

Outpatient and diagnostic and imaging departments were safe. Incidents were reported and staff knew how to do this and what to report. Learning had taken place in response to incidents.

The equipment and environment was clean, well maintained and there was adherence to infection control policies by the majority of staff. Systems were in place to manage and monitor cleanliness and these were implemented.

Patient records were stored securely but there were some difficulties regarding the access of historical data from the previous provider of the diagnostic and imaging service. There were risk assessments in place within the treatment centre. Staff working in the diagnostic and imaging service were providing a safe service according to their local rules.

Staffing levels across the outpatient's service were safe with actual staffing levels meeting the planned levels. There was a very low turnover of staff. The treatment centre had faced some challenges recruiting staff within certain specialities such as dermatology, however there was use of longer term contracts for temporary staff to provide continuity of care.

Incidents

- There had been one serious incident for outpatients between April and December 2014. Staff were aware of the incident, an investigation had taken place and actions had been implemented to avoid a repeat occurrence.
- Staff were familiar with the incident reporting system. They could demonstrate how they reported incidents. All staff we spoke with had been trained in incident reporting.
- The centre had an initiative called 'Stop the Line.' Any member of staff could stop activity if they felt patient safety may have been compromised. When "Stop the line" was triggered, there was immediate escalation of the issue and a resolution was developed immediately. All the staff we spoke with were enthusiastic about this initiative and were able to give examples of where they had used 'Stop the line.' We spoke with support staff to

ascertain if they felt confident to "Stop the line." We were told by three healthcare support workers about the times they had called a "Stop the line." They told us they were encouraged to use the process and they did not feel any pressure from senior staff to not follow the process.

- Learning from incidents took place through one to one's, daily huddles, partnership meetings, and leadership team meetings. All of the gateways held partnership meetings once every two months. Partnership meetings were multi-disciplinary. An example of partnership meeting notes from January 2015 recorded discussion, action, learning and clear reporting responsibilities.

Cleanliness, infection control and hygiene

- The treatment centre had reported no incidence of Methicillin resistant Staphylococcus Aureus (MRSA), clostridium difficile or, Methicillin Sensitive Staphylococcus Aureus (MSSA) in the reporting period April 2013 to September 2014.
- In all areas we observed staff to be complying with best practice with regard to infection prevention and control policies. Staff washed or applied gel to their hands between patients. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. All nursing staff and the majority of medical staff were observed to be bare below the elbow.
- All areas of the treatment centre departments were clean and tidy. We saw green 'I am clean' stickers in treatment rooms indicating they had been cleaned. These were signed and dated to signify when they were cleaned and by whom. Gateways had their own cleaning schedules. We saw cleaning schedules were signed daily and weekly depending on the requirements of the gateway.
- We observed all patient-care equipment to be clean and ready for use. We saw evidence of regular cleaning of equipment such as light therapy machines in gateway A.
- We saw evidence of 'damp dusting' (wiping equipment and surfaces by using a damp cloth) of x-ray equipment by radiographers. Records from January 2015 indicated that regular damp dusting had taken place. The superintendent radiographer told us that decontamination sheets were to be introduced to monitor and demonstrate the infection control of equipment. This meant that infection control records within diagnostic and imaging would become more comprehensive.

Environment and equipment

- Resuscitation equipment in radiology and outpatients was available. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence that the equipment had been checked daily by staff and was safe and ready for use in an emergency.
- In diagnostics and imaging, quality assurance checks were in place for each piece of imaging equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000). These protect patients against unnecessary exposure to harmful radiation.
- We saw that the treatment centre had implemented safety systems and practices to monitor imaging equipment. There were equipment logbooks and handover sheets to ensure constant monitoring of radiation equipment.
- A sharps box is a container that is filled with used medical needles and other sharp medical instruments. All sharps boxes were close to the point of use, secure, signed and dated on in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- The environment was clean and well maintained. Walkways were wide with no obstructions and people could move about the treatment centre safely. However we saw eight chairs that had not been cleaned and were ripped in the waiting area outside gateway A. We observed a patient examine one chair and elect to sit elsewhere.

Medicines

- The treatment centre conducted drug audits which helped to monitor when patient medication went out of date. This reduced risk of harm to the patient and enabled the treatment centre gateways to monitor stock of certain drugs and medications. We saw that medication kept on gateways were all in date. Medicine used for resuscitation was checked daily.
- Medicines were stored securely. Fridge temperatures were checked and recorded daily and were within an acceptable range.

Outpatients and diagnostic imaging

- Specialist medicines were safely prescribed and supplied individually for specific named patients. These were administered by two nurses against consultant signed authorisations and against standard protocols. Remaining medicines in both gateways were prescribed and administered using the treatment centre's standard prescription and medication administration record charts.
- To take out prescriptions (TTO) pre-packs were held on the gateways. They dispensed TTOs for individual patients. Nurses counselled patients at the point of discharge on how to take their medicines. The pharmacy team provided training for the nurses to do this.

Records

- In diagnostics and imaging, patient records were stored on the radiation information system (RIS) and picture archive communication system (PACS). These systems stored the entire patient imaging data as well as the radiation doses for patients. Staff could also scan manual requests and old style hard copy film into the PACS system. This meant that staff had access to comprehensive and historical records.
- All the staff we spoke with were aware of their responsibilities around the safe keeping of records and confidentiality of patient information. Patient identifiable information was stored securely in locked cabinets and rooms with keypads.
- We checked 18 sets of patient records. Notes were legible, name stamped, dated and signed so that anyone reading the notes was able to tell who had written them. The majority of the records contained copies of letters sent to the patients GP.
- Medical records were provided by a local NHS Trust. Consultants employed by the centre did not remove medical notes from the site. Consultants employed by the local NHS Trust who also worked at the treatment centre accessed and used notes on both sites but did not remove them from either premises.
- When a patient was booked into a clinic, administration staff ordered patient records from the appropriate trust. We observed staff checking patient's notes for clinics the next day so that any gaps or issues could be identified early. If a patient attended an appointment and their records were not available a temporary pack would be collated. The administrative staff would pull together as much information as they could retrieve.
- The treatment centre conducted audits to ensure systems were in place to make sure records were available for patient appointments.
- For the diagnostic and imaging services, the treatment centre had a service level agreement with the regional radiation protection service (RRPS). It was the responsibility of the RRPS to ensure records were available and stored appropriately. As a result staff said that there were rarely issues with the availability of patient records.

Safeguarding

- Data from the treatment centre highlighted that there had been no safeguarding alerts or concerns in the last 12 months.
- The treatment centre had a named nurse, named doctor and executive lead for safeguarding. The names of these individuals were available to staff and displayed on all gateways. All staff had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns.
- There was an e-learning module available for staff as part of their mandatory training for safeguarding and there was evidence in staff files that this had been completed. We saw from training records that 100% of substantive radiology staff had received safeguarding training.

Mandatory training

- Staff told us they were up to date with mandatory training and completion for the outpatients' team was 93% against a target of 80%. All staff we spoke with reported having good access to mandatory training and described being able to access training 'in-house' and, via an online learning service. Both substantive and bank/agency staff received the induction and mandatory training. We were shown a copy of a member of bank staffs induction checklist to support this.
- We saw evidence of mandatory training received for imaging staff. However the same mandatory training and induction had not yet been fully implemented for agency staff. The lead radiographer told us it was "work in progress."

Assessing and responding to patient risk

Outpatients and diagnostic imaging

- An emergency telephone line was available for staff to call in case of emergency or a deteriorating patient. A first responder team would attend the patient. There was a Responsible Medical Officer (RMO) on site 24 hours a day. Each of the gateways had advanced life support (ALS) and intermediate life support (ILS) trained staff available.
- Emergency lifesaving equipment was available and appropriately checked.
- Senior nursing and medical staff were able to tell us what their key risks were and how they were working to mitigate them. Staff were able to tell us how these were escalated by adding them to the treatment centre risk register.
- Medical physicists advised on radiation safety conducted quality checks. The RRPPS (Regional Radiation Protection Service) provided this service as part of a service level agreement.
- Radiation risk assessments were in place and available to staff. Hazard warning signs and lights were operational within x-ray rooms.
- Staff asked patients if they were or may be pregnant in the privacy of the x-ray room therefore respecting the privacy and dignity of the patient. This was in accordance with the radiation protection requirements and identified risk to an unborn foetus.
- Arrangements were in place for radiation risks within the comprehensive local rules. Local rules are the way diagnostics and imaging work in accordance with national guidance.
- In accordance with the ionising radiation (medical exposure) regulations (IR(ME)R 2000), policies and procedures were in place to identify and manage risks. The policies had been reviewed and signed by all staff.
- We saw that a Dexa scanner was on standby and the door to the scanning room was unlocked. Dexa scans check the 'density' of bones. This test uses X-rays to show how strong bones are. We informed the lead nurse who arranged someone from the X-ray department to switch it off. Whilst this was not directly harmful to patients and staff in the adjacent locality it was a potential hazard and it is good practice to switch the unit off when not in use.

Nursing staffing

- The establishment for nurse staffing across all outpatient departments at the treatment centre was approximately 58 whole time equivalents (WTE). This included a nurse manager, a nurse team leader, registered nurses and care assistants. The ratio of nurse manager to nurse team leader was 1 to 0.6. The ratio of nurse team leader to other nurse roles was approximately 1 to 13. The ratio of other nurse roles to care assistants was approximately 1 to 2.
- Nursing staff reported having enough staff on duty to deliver care effectively. Patients were all consistently positive about the number of nursing staff available and felt there were sufficient staff to meet their needs.
- The rate of agency staff use across most outpatient departments was 0% between June 2013 and November 2014. There were two exceptions; gateway A (dermatology) and gateway B (Cardiology, Vascular, Pain Management and Ophthalmology). Gateway B saw a rise from 0% to 11%. The increase in gateway B was due to service expansion and therefore more staff needed to be recruited. Recruitment of staff was on-going.
- Staffing levels were stable and there was very little turnover of staff. This meant there was continuity of care for patients. During our announced and unannounced visit actual staffing levels met the planned staffing lists. These were visible on boards on the entrances to gateways. We looked at staffing data between November 2014 and February 2015 and found the staffing levels were consistently in line with planned levels.
- The treatment centre used an acuity tool. This is a spread sheet that works out how many staff were needed for the different clinics. Every morning the lead nurse met with senior nursing staff on the gateways to discuss what staff were needed for the day. The acuity tool was also used to plan further ahead and to provide safe staffing levels when extra clinics were needed. A lead nurse told us that her staffing establishment had recently been increased to meet demand.
- Nursing staff had a meeting every morning on each gateway called a huddle during which they discussed the day's events, nurse staffing requirements against patient need and medical staffing levels. Nursing staff and senior nursing staff spoke about the ability to work with other gateways and "borrow" staff from other gateways during busy periods or to obtain the right skill mix of staff. This ensured the right number and skill mix of staff were available to ensure patients get safe treatment and care.
- Staff and patients consistently told us they thought there were enough staff working in the centre.

Outpatients and diagnostic imaging

Diagnostic and imaging staffing

- The vacancy rate for gateway C (Radiology) was 20% but this only equated to one staff member. This vacancy was filled by agency staff. Recruitment for staff in radiology was on-going at the time of our inspection.

Medical staffing

- There were 63 whole time equivalent doctors and dentists under rules or privileges and 12 whole time substantive (employed by the treatment centre). Two consultants on gateway A (dermatology) told us that they were concerned about the shortage of consultants for the gateway. One consultant said that there were a total of three consultants leaving the gateway soon. At the time of our visit gateway A had five substantive consultants and eight locums, one surgical fellow and a consultant nurse. We were told by the registered manager that there was difficulty in recruiting consultants to this gateway and that this was on the risk register. We did not find evidence to suggest patients care and treatment was being affected and the managers were proactively addressing the risks. The commissioners of the service were also fully aware about the plans to manage the risk.
- Where locums were used they were employed on long term contracts which meant that patients would receive continuity of care. The majority of patients were happy with their consultant and treatment.
- Nursing staff did not raise any concerns with us about the availability of medical staff. A lead nurse told us that the substantive consultants and locums "All worked as one team."

Major incident awareness and training

- The treatment centre was part of the nearby trust's major incident policy. Senior managers told us, if a major incident was declared in the locality the nearby trust would inform the treatment centre of their role. This had occurred recently in January 2014 when, the nearby trust had declared an 'internal incident' due to extreme pressure on the emergency department. The centre worked with the health community to offer support as needed.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

The centre was effective. Staff worked in line with local and national guidance. There was a good culture of multidisciplinary working between all departments and levels. Staff were well trained and supported to provide good care with mandatory and mental capacity act training rates better than treatment centre target levels.

Clinics ran from Monday to Friday with additional ad hoc clinics in the evenings and weekends. Staff and patients had good access to information. There were some issues within diagnostic and imaging regarding the access of historical data from the previous provider of these services.

Evidence-based care and treatment

- Both consultants and radiographers understood and demonstrated an understanding of their role in line with Ionising Radiation (Medical Exposure) regulations (2000) (IR(ME)R) regarding protecting patients from the risks of unnecessary exposure to x rays.
- Staff told us there had been difficulties accessing the previous dose reference levels (DRL) that patients had received. These are used to inform imaging staff what dose of radiation is needed to take an x-ray. This meant there was a risk that patients would have a higher dose of radiation than was necessary. The managers of the service were taking steps to address this problem.
- Local audits were undertaken to monitor care and action was taken in areas identified for improvement. There had been improvements in consent practices for outpatient departments with the introduction of new consent forms that were bespoke to the care pathway.
- Audits took place in outpatients and diagnostic imaging to ensure that staff had the correct information in order to deliver care and treatment. We observed vetting by radiologists to ensure that patients were receiving the right type and level of radiation dosage. This was in accordance with guidelines set by the royal college of radiologists.

Pain relief

- The treatment centre had a pain clinic which supported patients in managing pain for their conditions. The clinic provided patients with lifestyle plans to help them remain active and limit the amount of pain in daily life.

Outpatients and diagnostic imaging

Patient outcomes

- The centre participated in 100% of the national clinical audits it was eligible for.
- Local policies and care pathways were in place which were in line with national guidance. Policies were up to date.
- Staff were able to tell us about clinical audits that were undertaken and how they supported patient outcomes. Audits were undertaken on did not attend (DNA), waiting times, and cancellations. Any treatment centre initiated cancellations were monitored by the gateway coordinators and if necessary escalated to the relevant operations manager via a clear escalation procedure.

Competent staff

- All staff we spoke to told us that they received regular one to one supervisions, yearly appraisals and 360 degree feedback sessions every six months. The 360 degree feedback sessions involved a member of staff choosing a minimum of five people to comment and review their performance. We saw evidence of this in staff files across administration, nursing, and non-nursing health staff
- Outpatient's appraisal rates for all departments averaged at 75% between April 2012 and November 2014. The rates of appraisal within diagnostics and imaging were lower (60%) but this was to be expected as the service had only been in place for six months at the time of our inspection.
- There were procedures in place for granting and reviewing practising privileges. The term "practising privileges" refers to medical practitioners being granted the right to practice in a hospital. We saw where the treatment centre had implemented a robust system with a checklist and guidelines as to who was responsible for providing the information. Files had a checklist in them and these had been audited. Where there were gaps in required information we could see the treatment centre had emailed individuals to request information. Risk assessments of the impact of the lack of information were completed and the process had been identified on the treatment centre risk register.
- The proportion of staff whose professional registration status had been verified post-application check was 100% since November 2014. This included nurses and doctors employed by the treatment centre as well as the doctors working under practising privileges.
- The treatment centre was piloting the implementation of a care certificate for healthcare assistants (HCA's) achieved through a HCA training programme which offered specialty training and skills development. A senior healthcare assistant (HCA) told us they felt there were good opportunities for them to develop.
- Intermediate and advanced life support training had taken place. Staff updated their competency annually and monthly training scenarios took place.
- We saw competency frameworks for nursing staff and healthcare assistants. The frameworks identified the minimum standard and specialist knowledge that staff needed to undertake their role. We saw competency frameworks filled out for nursing staff, non-nursing staff and specialisms such as bladder scanning.
- There were also competency frameworks for bank and agency staff so that all staff could work at the same level. This meant patients could expect the same level of care and treatment from all staff.
- Quality assurance in radiology was in development. At the time of our inspection there were no mechanisms in place for learning from x-rays that had been rejected. This meant there were limited opportunities for staff to learn and develop their skills. We did see there were plans to develop this in the coming months.

Multidisciplinary working

- A multi-disciplinary team (MDT) approach was evident across all of the areas we visited. At our focus groups, staff told us there was good multi-disciplinary working and they felt part of a team. Several staff described how they though the multi-disciplinary working was exceptionally strong at the treatment centre.
- When a member of staff wanted to improve an aspect of the service they could call a '"Swarm."' A swarm was a multidisciplinary meeting that could be called by any member of staff at any point. It involved the key people that related to that particular issue which could be nurses, consultants, domestic staff, or the lead nurse. Minutes and notes of swarm meetings were placed on notice boards in clinical areas for anyone to read. An example of this was on gateway C where a swarm had been held on MRI staffing capacity.
- Every gateway had a daily huddle. These were five minute meetings where staff discussed patients, staffing levels, and pertinent issues. The huddles were used to

plan services, share information from leadership team meetings and learning. Staff were positive about the huddles and thought that they contributed to positive team working and better service delivery.

- Every two months gateways had partnership meetings. These were used for information exchange, learning from other professionals or other gateways and discussing changes to policies. They were multi-disciplinary meetings where people came together to problem solve and discuss better care for patients. We saw notes from partnership meetings displayed in most gateways so that all staff and patients could see what was discussed and outcomes of discussion.
- The cancer team had multi-disciplinary team coordinators for different types of cancer specialties such as skin and urological gynaecology. The coordinators attended and prepared the treatment centre MDT meetings. They worked collaboratively with surrounding trusts based in Nottingham, Derby, and Lincoln hosting quarterly strategic cancer network meetings.

Seven-day services

- The centre was open to patients between 07:00 and 21:00 each day Monday to Friday. Additional clinics ran on a Saturday when there was a high demand.
- Consultants practising within the centre were responsible under practising privileges for care of their patients 24/7. There was an Responsible Medical Officer (RMO) within the centre 24 hours a day with immediate telephone access to the responsible consultant.
- Pharmacy services were available in hours and there was an on call pharmacist contactable out of hours.
- Physiotherapy services were provided by an independent provider and provided inpatient cover Monday to Friday and at weekends as dictated by patient need.
- The centre was also supported by an on call lead nurse, on call Senior Manager, on call engineer as well as information technology support.

Access to information

- We saw that there was a large amount of information available for patients on leaflet racks and noticeboards. The information on each gateway was relevant to the types of clinics delivered there. The information was a mix of details about the types of treatments available, about different conditions and how to self-manage them. We saw patients being given information on gateway A before and after treatment.
- The lead radiographer had replaced existing information leaflets with new information for patients. This was in response to patients not understanding the information in the leaflets and an attempt to tackle Did Not Attend (DNA) rates.
- We saw that information was available to patients on several gateways to help prepare them for treatment. For example on gateway A we saw information on light therapy services, information on the types of clothing patients should wear, and moisturisers to be used. Two patients told us that they had received this information before their treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they were aware of the treatment centres policy on consent. Consent was sought from patients prior to the delivery of treatment; patients we spoke with told us that they felt involved in decisions about their care.
- Two members of staff on different gateways gave us examples of when treatment had not gone ahead because a patient was distressed and consent could not be obtained. Both members of staff were able to talk about best interest decisions and consent.
- We looked at four sets of patients records to see if consent to treatment had been obtained. We saw that in all four patients records consent had been obtained from the patient.
- Nursing staff told us that if they were worried about consent they were able to discuss with the consultants or go to a manager.
- As part of the induction and mandatory training programme staff had received training on the Mental Capacity Act and dementia awareness training. All staff we spoke with demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 and knew what to do where patients lacked the mental capacity to give consent for themselves. The treatment centre target for compliance with training around the mental capacity act was 80% and the outpatient service exceeded this target at 87.5% of staff had received training.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Good

Outpatient and diagnostic imaging services at the treatment centre were caring. Staff were passionate about patient care and we observed numerous positive interactions between staff and patients. The majority of patients felt involved in their care and were happy with their experience in the department. Staff provided confidential emotional support for patients and private areas where staff could break bad news for patients.

Compassionate care

- We observed staff treating patients with dignity and respect. We saw one member of staff assisting an elderly patient to the right gateway. All staff we spoke to explained the importance of privacy, dignity, and confidentiality. Staff asked patients if they were or may be pregnant in the privacy of the x-ray room therefore preserving the privacy and dignity of the patient.
- There was a compassionate and patient centred culture at the treatment centre. Radiology and outpatients staff at all levels told us about their passion to ensure patients received the best treatment and care.
- The majority of patients were very positive about their experience in the treatment centre. Only one patient out of the 28 we spoke with told us that their care was not compassionate. They described how they felt they had been rushed and their needs were not fully attended to.
- Throughout our inspection we observed positive interactions between staff and patients. Patients were cared for with nursing and non-nursing staff displaying attentive and caring behaviour. Reception staff were friendly, polite and greeted patients with a smile. Nursing staff ensured patients had everything they needed and were comfortable.
- Treatment rooms had additional modesty curtains and lockable changing rooms. This meant patients who receiving treatment or changing for treatment could have the right level of privacy. We observed staff knocking on doors before entering changing rooms and asking for patients' permission to enter.
- Changing rooms in gateway C (Radiology) had double access doors so that patients would not accidentally gain access to controlled radiation areas. There was a lock for the patient to maintain their privacy but a second door could only be accessed from inside the imaging room by a member of staff.
- There was a private waiting area after patients had received light therapy treatment which was separated by a privacy curtain. Patients who had treatments applied to their skin could also wait in there. We spoke to two patients in the waiting room who said that they had no concerns about privacy and dignity. They told us that they were allowed to wear what they wanted (for example shorts and t-shirt) instead of being made to wear gowns which made them feel at ease. They also told us that they felt comfortable in the waiting room but sometimes the privacy curtain was left open and people could see inside. This made them feel exposed but it was rare that this happened.
- The treatment centre used the Friends and Family Test (FFT). This was a single question survey which asked patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. FFT scores and response rates were displayed on boards in all outpatient departments including radiology.
- The centre had high FFT scores which were above the treatment centre target of 80. Outpatient departments were scoring over 90 according to the latest data for both NHS and privately funded patients meaning patients were happy with their treatment and care.
- Response rates to the FFT had varied and ranged from45% in July 2014 to just under the centre target of 20%.

Understanding and involvement of patients and those close to them

- Staff on the gateway reception desks were polite and kept patients informed of waiting times via an electronic board or by explaining in person. We observed nursing staff in clinics explaining to patients why there were delays to treatment.
- We observed in gateway C (radiology) patients being informed of when and how they would receive their imaging results.
- Patients told us they felt involved in their care and treatment. Staff also told us about patients being given contact nurses for some clinics so they had a point of

contact. We saw evidence of how staff had involved patients in their care recorded in patients' medical notes. We observed nursing staff talking through treatment and care with patients.
- The majority of patients told us that they felt informed about their care and treatment by nursing and medical staff.
- Most of the patients we spoke to said that staff communicated well, were professional and well organised. Patients spoke of this having a calming effect on them and an impression that staff knew what they are doing.
- Two patients felt that they were not involved in their treatment or care as they would have liked.

Emotional support

- There were a number of ways that patients were supported in the centre. Chaperones and key workers were available for patients with complex needs. They supported the patient and explained the care and treatment options available to them. There were specialist nurses available to support patients if they have been given bad news. For example nursing staff told us about the cancer stoma nurses who could sit and explain what would happen next.
- There were private rooms available in some of the gateways within the centre for patients who had received bad news. Two members of staff told us the private rooms were not in each gateway. Patients given bad news were also given a patient pack with information about the illness. This included information on how to get support from other organisations such as Macmillan.

Are outpatients and diagnostic imaging services responsive?

Good

The outpatients and diagnostic imaging services were responsive to the needs of patients.

The majority of patients were seen within 18 weeks with the average waiting time for a patient being eight to 11 weeks. Waiting times for diagnostic tests were between one to six weeks which were better or in line with the national target of 6 weeks.

Patients told us parking was problematic. This was exacerbated by the tram works taking place outside the centre

Attendances for clinics were rising however the treatment centre had a flexible approach and was able to meet the demand. The environment was comfortable and attractive for patients waiting for appointments. Some clinics did run late at times but patients were kept informed of delays.

There were translation services available for patients. There was a positive approach to learning from complaints and concerns and we saw examples of where changes had taken place.

Service planning and delivery to meet the needs of local people

- The environment was comfortable for patients and those close to them. There were plenty of seats for waiting patients. There was a café where patients or those close to them could purchase food or drinks while they waited for clinics or friends/relatives.
- The waiting rooms inside the gateways all had additional refreshments available for patients.
- When patients arrived and booked in for their appointment they were given a buzzer which vibrated when they were called for their appointment. We observed the system in use and it enabled patients to sit in the coffee shop, walk around or go to the toilet without worrying about missing appointments. This reduced the amount of patients waiting at the gateway reception during busy periods and patients were able to move freely around the centre.
- The treatment centre also had free Wi-Fi for patients to use. This was highly valued by some of the patients.
- Five patients told us that it was difficult parking at the treatment centre. This was due to tram works taking place outside the treatment centre which caused disruption to traffic flow and reduced the number of parking spaces. The patients we spoke to said that the treatment centre should let patients know about parking difficulties in their letters to patients so that alternative arrangements could be made. However, the tram works, when completed, would enable more patients to access the treatment centre by public transport. The tram would stop directly outside the treatment centre.
- The number of patients accessing clinics was getting larger. For example attendances in gateway A (new and

follow up appointments) had risen by just over 5% to 56,210 attendances in 2013. This was due to an increasing amount of patients who had more complex needs as well as an increase in the contract with the commissioners. In order to meet this demand staff told us the treatment centre put on more clinics and recruited more staff both on a short term and long term basis. A lead nurse told us that between 10 and 20 ad hoc clinics were put on each month in their clinic to meet increased demand. This demonstrated that the treatment centre were responding and planning services to meet the demands of patients.

Access and flow

- The Referral to Treatment (RTT) operational standard for the treatment centre was 90% of patients should start consultant-led treatment within 18 weeks of referral. From April to November 2014 the treatment centre had performed better than this target and patients attending the centre were starting treatment within eight to 11 weeks of referral.
- The national cancer plan and the 2011 cancer reform strategy indicate that there should be a maximum two week wait from an urgent GP referral to when the patient is first seen. Data from the treatment centre between October and December 2014 showed that 909 out of 954 (95%) patients had been seen within two weeks.
- National guidelines state that patients should not wait any more than six weeks for a diagnostic test. The imaging department had increased its opening hours for magnetic resonance imaging (MRI) scans to two 12 hour days and every Saturday morning to accommodate demand and keep waiting times under four weeks.
- Since September 2014 the treatment centre had seen a reduction in waiting times for reporting results. This is from when a request for an x-ray is submitted to when the results are available. Waiting times for most types of scans including CT, MRI had reduced by half. Waiting times were between one and six weeks for diagnostic tests which were better or in line with national targets. This meant that patients were getting access to treatment in a timely manner.
- Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. Patients told us that the referral system worked well. Senior nursing and administrative staff told us there were no concerns that GP's and patients were unable to book slots for treatment.
- Waiting times for patients once they arrived in the department were displayed on electronic boards so that patients could see how long their wait would be. The majority of patients did not have any concerns about their wait and felt that waiting times were short. Patients also commented on how organised the gateways were.
- We saw examples of gateway teams communicating any delays in waiting for appointments. Nursing staff communicated with reception staff who informed patients of any long waiting times.
- The diagnostic and imaging department had a walk in zero wait system for patients. This meant patients who attended a clinic and required an x-ray received one on the same day without having to wait and come back another day. The image was loaded onto the picture archive communication system (PACS) system and was available to view when the patient returned to the clinic. A patient told us that he had come to the treatment centre for an x-ray and was impressed that the follow up with the consultant would be carried out the same day.

Meeting people's individual needs

- Translation services were available and translators were booked when a referral arrived at the treatment centre. Nursing staff told us that occasionally they used language line (a telephone interpreter service) if no interpreter had been booked or was not available. They told us this was not ideal and could provide difficulties depending on the complexity of the discussion needed with the patient.
- Patient information could be translated into different languages if required. Nursing staff told us that information and leaflets were translated at the booking stage if a need was identified.
- If a patient had learning disabilities this was identified at the appointment booking stage. Patient notes were prepared by administrative staff so that the right support could be put in place. The treatment centre worked with the learning disabilities nurse so that people could be supported appropriately.
- Chaperones were available to patients and there was information clearly displayed in the waiting area about the services. Booking staff told us that they were usually booked in advance either via patient or GP request.

Outpatients and diagnostic imaging

- There were a number of prisons in the local area. People who were detained accessed the centre for a number of conditions. Nursing staff told us that they ensured secure and private rooms were available for prisoners to wait and receive treatment. This was to preserve their privacy and dignity.
- We saw on gateway A that day treatment and light therapy patients had their own separate entrance into the gateway Light therapy patients can have severe skin conditions and this separate entrance ensured that they could enter the gateway Without having to go through the main reception areas if they so wished. This was an example of providing a considerate service for people with specific needs.
- The treatment centre worked flexibly around patients that had mobility issues. We observed the treatment centre had plenty of space so that people in wheelchairs could get around and access facilities. Hoists and trolleys could be booked for people with mobility difficulties.
- In gateway C (radiology), we were shown by a member of imaging staff that there were difficulties when taking x-rays of people who had mobility difficulties. Whilst staff could get access to hoists they could not be used correctly with the type of imaging beds in use. The staff had to manually assist the patient into the correct position. This posed a risk to the health and safety of staff and was not always comfortable for patients.

Learning from complaints and concerns

- The treatment centre had information for patients on how to make a complaint. However providing information about how to make a complaint was inconsistent. Some gateways had clear information visible on walls and leaflet racks and some gateways there was very little information available.
- Staff were aware of the complaints procedure. The centre actively promoted the four Cs process (complaints, concerns, comments and compliments). We saw where the four Cs were reported quarterly as part of the centre's 'quality quartet' scorecard. Staff told us the four Cs would also be discussed at the staff partnership sessions.
- We saw discussion and learning from complaints had taken place in partnership meeting notes from 9 January 2015 and 18 December 2014. Complaints were also discussed at morning huddles and team meetings. Complaint themes and key learning were reviewed at the Clinical Governance and Risk Committee and disseminated throughout the centre. Each gateway had a 'you said, we did' board identifying changes that had been made from complaints.
- Staff told us if someone had a concern or a complaint they would try and deal with the matter there and then. Failing that they would provide the patient with a feedback card and escalate the issue to their manager. This was in accordance with the centres policy on handling complaints.
- Three patients told us if they had a problem they would know where to go with it and were confident to raise concerns or complaints.
- Formal complaints were received by the governance team and were documented on the incident reporting system. Any complaint response letters were checked by both the governance team and the centres general manager to ensure the complaint had been dealt with effectively.

Are outpatients and diagnostic imaging services well-led?

Good

Staff were committed to the treatment centre's objectives and values. The majority of staff we spoke to mentioned the treatment centre's credo and valued it.

Morale was excellent with staff very positive about the organisation and their leaders. Staff felt supported and encouraged to develop a culture of collaboration, innovation, and learning. This was demonstrated by a low turnover of staff across outpatients.

Vision and strategy for this service

- The treatment centre had their own 'credo'. This described their purpose, parameters and principles for healthcare provision. We saw where this was clearly visible throughout the areas we visited. Most of the staff we spoke to were able to refer to the credo and explain how their role fitted in with it.
- The treatment centre's 12 point plan was visible on all gateway noticeboards. Most staff we spoke to mentioned the 12 point plan.
- We saw the corporate vision and values displayed on gateway notice boards. Every gateway had a circle

operating system noticeboard which contained the credo and the development of the 12 point plan. When asked the majority of staff including diagnostics and imaging could refer to the vision and values and the credo.

Governance, risk management and quality measurement

- We saw a clear escalation and risk management processes were in place. When talking with staff they told us who they escalated issues or incidents to as per the treatment centre access policy.
- For outpatient departments we found that staffing was very stable. Staff turnover was low. Senior administration staff told us that the majority of them had been in post for longer than a year. This was because they were proud to work at the treatment centre and they felt appreciated.
- Staff felt listened to and were confident to raise concerns or suggest improvements to services. The use of stop the line was evident and staff at all levels told us they had used stop the line, were confident to do so and that action was taken in response to any patient safety concerns.
- There was a risk register in place for the treatment centre. We saw this was up to date and risks were mitigated. Risks had a named lead who was responsible for the actions. The risk register was monitored through the clinical governance and risk management committee.
- There was a monthly clinical governance and risk management committee which was responsible for monitoring the quality of the services across the hospital. Each of the gateways had clinical governance meetings and they reported into the overarching governance group. The leadership team had oversight of key performance indicators. There were standing agenda items such as number of patient harms, incidents and complaints.
- There was a positive working relationship with the commissioners of the service. The commissioners reviewed performance of the treatment centre on an on-going basis. senior staff worked with the commissioners to ensure the needs of patients were met. For example, the treatment centre had taken on work from other providers at short notice in order to help pressures within the NHS system.

Leadership of service

- Radiology services were well led. There was evidence of substantive and bank staff working together as a team and communicating well. Staff also told us that they felt supported and directed by the clinical manager and the lead radiographer. The leadership team had ensured that staff were able to be a part of the vision for this new service.
- Nursing, medical and administrative staff told us that leaders were visible and approachable and that they felt supported by their managers. Nursing staff told us that it was easy to raise concerns and issues.
- Leaders were encouraged at all levels. We were given examples of various meetings where staff discussed issues, shared learning and knowledge.
- Lead nurses were available in all gateways and were available to staff. All senior nursing staff we spoke with told us they were proud of their staff Senior nursing staff told us that they were passionate about the development and wellbeing of staff. Without exception, nursing and non-nursing staff on the gateways told us they felt valued and supported by senior nursing staff.
- The centre had a staff award scheme called, “Star on the month.” Colleagues nominated each other and prizes were awarded. The “stars of the month” were displayed in the gateway areas.

Culture within the service

- All staff we spoke with said that they enjoyed working at the treatment centre.
- We were struck by the number of staff who spoke so highly about working at the centre and how good it was to be employed by Circle Nottingham. Staff were very proud, morale was extremely high and we noted staff appeared calm and relaxed. At our staff focus groups they told us there was respect between different groups of staff and there was no sense of hierarchy in the centre. Engagement between staff and managers was good and worked well. Staff felt valued because they were given opportunities to give their opinions, make changes to improve the service and they were also given rewards such as free fruit every day. Staff felt the company cared about their well-being.

Public and staff engagement

- Staff satisfaction was reviewed twice a year and results were recorded on the treatment centre’s performance

system. It was reviewed by the senior management team and themes and trends were identified and actioned. Administration and nursing staff gave an example of them getting involved in changing staff uniforms as a result of the staff satisfaction survey.

- Partnership sessions were held within clinical units and were open to all staff involved in the patient pathway. The purpose of the sessions was to improve competence and educate staff, enable discussions of any issues that had arisen and provide the opportunity to develop realistic and effective solutions. All staff we spoke with across endoscopy and the day case and short stay units had attended these partnership sessions and valued them.
- The treatment centre had a patient participation group whose aim was to engage with patients and represent their voice to staff. We spoke with six volunteer members, most of whom have used services at the treatment centre. They told us that staff listened. They gave us an example of the café opening on a Saturday as a result of patient feedback.
- The patient participation group told us that they also took part in the gateway partnership meetings and the leadership meetings for senior managers. The groups felt they were embedded within the governance structure of the centre.
- Patients were asked to give feedback either on paper forms or electronically. There were tablet devices attached to walls where the patient could answer questions about their experience. There were posters encouraging feedback placed above the tablets but these were not very prominent. We did not see staff directing patients to the tablets.

Innovation, improvement and sustainability

- We saw improvement was taking place within the diagnostic imaging. This was a new service and was still in its infancy after being transferred from a local NHS trust. Plans, policies, and staff were still being put in place in accordance to national and local rules.
- A senior member of nursing staff told us they were developing a new role to meet the needs of patients who had conditions with their hands. The new role would combine Occupational Therapy, Physiotherapy as well as nursing together and would decrease the number of patients waiting to be seen by different people.
- In diagnostics and imaging there was work in progress to develop a radiation protection committee (RPC) that would report to the centres management safety group. this was good practice and would enable key risks in diagnostics and imaging to be discussed.
- Staff told us that they were encouraged to change the way services were run and suggest improvements. A Health Care Assistant (HCA) told us staff were encouraged to put forward ideas. We saw examples of this taking place.
- The treatment centre was piloting the implementation of a care certificate for healthcare assistants (HCA's) achieved through a HCA training programme which offered specialty training and skills development.

Termination of pregnancy

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

Information about the service

The Nottingham NHS Treatment Centre holds a licence from the Department of Health to undertake surgical terminations up to the 14-week gestational stage. The licence was displayed at the entrance to the Treatment Centre. The service is currently offered to women aged 18 upwards. The centre recently made a decision not to offer the termination of pregnancy service to patients below the age of 18.

All patients were referred for surgical terminations to the Nottingham NHS Treatment Centre following consultations at either the Victoria Health Centre (VHC) or Nottingham Unplanned Pregnancy Advisory Service (NUPAS). Both of these services were provided by other organisations and were not part of this inspection.

During the period March 2013 – April 2014, 992 terminations of pregnancy procedures were carried out at the centre.

We spoke with two patients during our visit. We also spoke with 15 staff, including: the Consultant Head of Gynaecology, managers, a range of doctors and nurses and administration staff. We observed care and treatment and looked at the care records of eight patients.

Summary of findings

Overall, we found termination of pregnancy services required improvement.

The termination of pregnancy service was fragmented and lacked cohesive leadership, team identity and systematic working practices. There were very limited opportunities for staff to meet and consequently, whilst there was some governance and monitoring of the service in place no one took responsibility for ensuring that findings were used to improve the service.

There was a shared care pathway with other providers. Work was being put in place to meet with other providers and improve communications and systems. Sometimes care and treatment wasn't delivered effectively, particularly the taking of blood samples to establish if Anti-D treatment was required. As a result patients did not always receive the right treatment.

Although we found the staff were very caring and patients were positive about their experience, not all patients were offered counselling prior to their procedure. We also found not all staff involved in counselling of patients were trained to the level required in the required standard operating procedures.

Procedures did not always take place within the Department of Health required standard operating requirement of 10 working days. This was attributed to appointments being made by other providers. Referral to treatment times showed that 21% of procedures

exceeded 10 working days. The reason for the delays was not recorded. Where patients were near to 14 weeks gestation there were systems to fast track procedures to limit the future risk to their health.

Are termination of pregnancy services safe?

Good

Overall we found termination of pregnancy services to be to be safe.

The service had robust processes in place for the investigation of incidents, near misses and never events. Staff demonstrated a good knowledge of the processes for reporting incidents. Some trends were identifiable within the incidents but learning had not been implemented to prevent reoccurrence. Most staff received some feedback regarding incidents however this was not the case for medical staff.

Patients were offered pain relief, prophylactic antibiotic treatments and post-surgical contraceptives. The centre was clean with suitable equipment available.

Patient records were completed and were stored securely. Care records were fully completed. However information was not stored in a systematic manner due to different referral forms being used which made it difficult to access information quickly.

There were sufficient numbers of suitably trained staff available to care for patients. Staff were aware of safeguarding procedures and had received training in safeguarding adults.

Incidents

- An online incident report system was used. All staff we spoke with apart from one were familiar with how to use this and gave us examples of incidents they had reported.
- The centre has a ”Stop the Line” process which enabled staff to immediately alert senior staff if they were concerned about any health and safety matters. There was a clear emphasis on patient safety and the process enabled staff to stop the line if they were concerned about the care being delivered to patients. Staff told us they were familiar with the “Stop the Line” process and gave examples where this had been initiated.

Termination of pregnancy

- Following a "Stop the Line" report it was expected that a 'Swarm' be held quickly. A swarm was a meeting of key staff who have the authority to make rapid decisions to fix the problem.
- We reviewed the incidents that had occurred over the past year during the termination of pregnancy care pathway. This showed that staff were reporting incidents in accordance with the centre's guidance.
- An incident report for the termination of pregnancy service demonstrated that staff had escalated their concerns appropriately; however, not all incidents recorded the lessons to be learned.
- Most staff told us they did get feedback from incidents although some staff told us the learning cascaded only related to incidents they were involved in. Two sessional medical staff however told us they did not receive any feedback from incidents.
- Senior staff told us they received copies of all incident reports throughout the centre so knew about the incidents relating to other areas.
- Monthly Clinical Governance & Risk Management Committee meetings were held. These were attended by a wide range of staff. Incidents were discussed at the meetings including any learning and actions that were required.

Cleanliness, infection control and hygiene

- Audits and checks were in place to monitor standards of cleanliness. Staff told us that monthly infection control audits were completed by staff who were designated leads for infection control.
- Hand gels were available at the entrance of the treatment centre, on reception desks and at the doorways to the Gateways (the treatment centre areas are described as 'gateways' to help patients find their way to the correct are they need),.
- Staff told us there were sufficient supplies of personal protective equipment (PPE) such as gloves and aprons and we saw staff wearing appropriate PPE.
- We observed some staff to be wearing hand and wrist jewellery and nail varnish which was not in accordance with the centre's infection control policy.
- All areas were observed to be clean with the exception of one light-fitting in a treatment room. The cover of the fitting was open and there was an excess of dust within the fitting, There had been no reported hospital acquired infections over the past year.

Medicines

- Medicines, including those requiring cool storage, were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. We saw controlled drugs were stored and managed appropriately. Emergency medicines were available for use and there was evidence that these were regularly checked.
- Post-surgical antibiotics were prescribed to all patients to reduce the risk of infection.
- Patients were asked if they had any known allergies. Where patients were aware of allergies they wore red wrist bands to alert staff of this.
- We looked at two medication administration records. Neither of these was completed in accordance with best practice and the writing was not clearly legible. The route of administration was not clear. The date prescribed boxes were marked with one date and subsequent prescriptions written below were marked with a 'ditto' not with actual date of prescribing. There was a risk that the chart could be mis- read and the wrong medicine or dose given.

Records

- All patient records were paper based. Patient records were held securely and kept in boxes or trolleys.
- We observed that where staff left reception desks they ensured other staff were available to protect the confidentiality of paper and computer records.
- The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for the termination and sign a form to indicate their agreement (HSA1 Form). We looked at eight patient records and found that all forms included two signatures and the reason the termination.
- The Department of Health requires every provider undertaking termination of pregnancy to submit demographical data following every termination of pregnancy procedure performed. These contribute to a national report on the termination of pregnancy. On two of the HSA4 forms, we found three errors. Two forms did not accurately record the ethnicity of the patient; the third error was incorrect recoding of the marital status of the patient. We alerted staff to the errors during our visit.

Termination of pregnancy

- On the records audits we reviewed for October 2014 the ethnicity of only one out of nine patients was recorded. Two further audits had gaps or 'not known' recorded.
- Confidential waste bins were readily available to ensure records were suitably disposed of.
- Patient care files contained a high number of loose pages; this increased the risk of loss of personal data and misfiling.
- Referrals from other agencies containing personal information were sent by fax through to a 'safe haven' fax number. This meant patient's confidentiality was protected.

Safeguarding

- Staff knew who the safeguarding lead was for the centre and where to seek advice.
- Suitable safeguarding adult procedures were in place with the policy stating that agreed multi –agency procedures were to be followed if abuse was suspected.
- All staff we spoke with had received safeguarding training and knew how to report concerns.
- Each area had a safeguarding folder for staff to access if they needed information.

Mandatory training

- Staff employed by the centre told us their training was up to date and they could easily access training. Email reminders were sent to staff to inform them that training was due. Data we looked at showed the rates for mandatory training within the gynaecology gateway were 63.8% in 2013/14.
- Staff appraisals were completed on a six monthly basis.
- There were competency based induction packages available for a range of roles.
- We spoke with one newly qualified nurse who told us they had a mentor and were fully supported through a preceptorship programme.
- The responsibility for the delivery of mandatory training to sessional staff lay with Nottingham University Hospital under a service level agreement. The training records provided for sessional staff showed that they had received mandatory training in the past year. This meant that patients were cared for by staff who were suitably qualified.

Assessing and responding to patient risk

- There was a defibrillator available on each Gateway which staff were trained to use should patients have a cardiac arrest (the treatment centre areas are described as 'gateways' to help patients find their way to the correct are they need),. The equipment on the gynaecology Gateway was checked on a daily basis to ensure it was working.
- During surgical procedures, staff used the World Health Organization's (WHO) 'safe surgery checklist', which is designed to prevent avoidable mistakes. These were completed appropriately In the patient records we reviewed.
- Nursing staff within the recovery room had good access to medical support in the event of a patient's condition deteriorating. Staff reported timely access to the on-site resident medical officer and the anaesthetist should a patient require immediate medical input. Throughout our inspection we observed the consultant within the recovery room checking on patients and their condition..

Nursing staffing

- The Unplanned Pregnancy Assessment Clinic at the centre was staffed by sessional doctors and nurses from Nottingham University Hospitals. Rotas showed that a core group of six nursing staff had worked within the clinic in the past six months. Most sessions were staffed by the same staff with other staff stepping in to provide holiday and sickness cover. There were no reports of cancelled clinics.
- For pre and post-surgical care there were sufficient staff on duty to care for patients. Managers and staff told us that staffing arrangements were flexible according to the dependency needs of patients on the theatre list.
- For the surgical lists which were dedicated to termination of pregnancy procedures, an additional staff member was rostered on duty in recognition to the pre- surgical care required and to provide emotional support to patients.

Medical staffing

- There were sufficient and suitably qualified medical staff available. There were eight consultants at the centre who undertook termination of pregnancy.
- We looked at three staff files of medical staff who were working under practising privileges. These showed there was a robust process in place to ensure that suitable checks were in place to enable staff to practice. The range of checks included Disclosure and Barring Service checks (DBS), references and revalidation reports.

Termination of pregnancy

Major incident awareness and training

- The centre had a business continuity plan in place. The service had staged some mock scenarios to test out the plan.. This included a bomb threat and a fire where full evacuations of areas were conducted.
- The centre had a dedicated team of staff who would respond in the event of a medical emergency.

Are termination of pregnancy services effective?

Requires improvement

Overall we found termination of pregnancy services required improvement.

Procedures for assessing and delivering Anti-D injections for patients were not robust. We found some patients did not have their blood tested before their surgery which posed a risk they would not get the required treatment.

There were procedures in place to assess and monitor individual patient risks.

Patients received pain relief and guidance on how to manage their pain after discharge. Contraception was discussed with patients and made available to them after procedures had taken place. There was a range of information available to patients and they were provided with a 24 hour helpline where they could get advice after discharge.

All staff received appraisals by their substantive employers. However, the centre did not meet a Department of Health requirement that all staff involved in pre-termination assessments were trained to diploma level in counselling.

Evidence-based care and treatment

- A range of policies and procedures were available which reflected Department of Health standard operating procedures and professional guidance. However, the service did not consistently implement the policies and procedures and we found inconsistencies in practice where policies were not adhered to.
- All patients underwent an ultra sound scan to determine gestation of the pregnancy. This was mostly carried out by the referrer. Only where there were queries on the accuracy of the first scan was a second scan performed at the Treatment Centre. When needed, there was scanning equipment available.
- We saw that records contained venous thromboembolism risk assessments (VTE); these were completed prior to patients receiving surgery. The risk assessments informed staff if prophylactic treatments were required. Audits of pre admission checks showed that VTE assessments were routinely completed.
- Prior to termination procedures all patients should have a blood test to identify their blood group. It is important that any patient who has a rhesus negative blood group receives treatment with an injection of anti-D. This treatment protects against complications should the patient have future pregnancies.
- Most patients had their blood test results available prior to attending for the procedure. This responsibility lay with the referring agency. However we saw there were occasions when patients attended the centre without their blood results being available. This meant patients had to wait for their results before being discharged.
- One incident record described where a patient did not receive their Anti-D immunoglobulin injection which was clinically required. Anti-D immunoglobulin is a medicine which is used in preventing antibody formation in rhesus negative women who have a rhesus positive baby. Anti-D immunoglobulin is given to the mother to reduce the chances of these antibodies being formed and any subsequent complications. This can lead to complications that may affect the baby after birth, or complications with a different pregnancy at a later stage should the mother become pregnant again.The learning outcome from the investigation was that patients should not leave the centre before their blood results were available. This had not been fully embedded into practice because audits showed that between October 2014 and January 2015 three patients had had been discharged home without their rhesus status being established. This meant that patients may not have received all the clinically indicated treatment which could adversely affect future pregnancies.
- We saw three medication records where patients had undergone the surgical procedure before their blood results were known, so it was not established if anti-D was required. Despite this, Anti-D treatment had been prescribed on the patient's medication record. This increased the risk of the drug being given when it was

not clinically required. This goes against General Medical Council (GMC) guidance which states that doctors are to 'prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the patient's needs'. One incident was recorded where a patient was given an Anti-D injection prior to blood results being available.

- Referring agencies discussed contraceptive options with patients prior to procedures taking place,. The audits of records showed that patients were provided with contraception at the centre post-surgery.
- Staff we spoke with told us that sexual health screening was available. They told us that this was offered to most, but not all patients. Staff told us they sometimes used their judgement when deciding whether to offer sexual health screening. The policy and procedure in place described that all patients had an option of Chlamydia and Gonococci screening as well as sickle cell where relevant but this was not offered in practice.
- Suitable procedures and arrangements were in place to dispose of foetal tissue. This included where there was foetal abnormality or the possibility of criminal proceedings where rape was suspected. Patients were informed about the usual arrangements for foetal tissue disposal in the surgical termination information leaflet but they were informed they could discuss other options with staff.

Pain relief

- We spoke to two patients and observed the care of patients. Both patients told us their pain was effectively managed. We observed one patient to be in obvious discomfort despite pain relieving medications being given.
- Pre and post procedural pain relief was prescribed on medication records. Best practice was followed as **non-steroidal anti-inflammatory drugs were usually prescribed which are recognized as being effective for the pain experienced during terminations of pregnancy.**
- **The post-surgical care leaflets included space to inform patients what time their pain relief was next due, this ensured there was the right time interval between doses.**

Patient outcomes

- The pre-assessment appointment time allotted for each patient was 30 minutes. This was to include time with a nurse and a separate consultation with a doctor to record the patient's history, physical observations and counselling. Staff told us that appointments often overran as patients could become upset and need emotional support.
- All termination of pregnancy procedures in the past 12 months were reported by the provider as being effective without any complications being experienced.

Competent staff

- Sessional staff employed by Nottingham University Hospital were receiving regular appraisals and supervision. Although staff confirmed this to us, there were no follow-up processes in place to check that these were being completed; we were told that if there were concerns about staff the service level agreement meant that Nottingham University Hospitals would alert the centre.

Multidisciplinary working

- One staff member told us that there had been meetings to improve pathways and working relationships with other agencies who provided part of the care pathway. These were ongoing.
- Patients were asked if they wanted their GP to be informed by letter about the care and treatment they received. We saw that patient's decisions were recorded and their wishes were respected.

Seven-day services

- All terminations of pregnancy were carried out as day surgery at the Treatment Centre. It is an expectation that patients have access to a 24-hour advice line should they be worried and require advice. The Treatment Centre had a unit which was staffed 24 hours per day, seven days per week which provided this service.
- Surgical procedures took place Monday – Friday with extra surgery lists on some Saturdays to cope with increases in demand.

Access to information

- A general guide for patients attending the Treatment Centre was available. There was also a leaflet dedicated to informing patients about what to expect when undergoing a surgical termination. This included any potential risks.

Termination of pregnancy

- Nurses undertaking pre-surgical assessments had a range of information available to them that they could give to patients as required. This included details on services to support women who were victims of domestic violence and how to access sexual health clinics.
- Leaflets were given to patients to inform them what to expect after the procedure. This included a 24 hour telephone number of where patients could seek advice if they were worried.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated good knowledge of the Mental Capacity Act and how this applied to patients.
- The care records we reviewed contained signed consent from patients. Possible side effects and complications were recorded; these had been explained to patients.

Are termination of pregnancy services caring?

Good

Patients were well cared for. They were positive about the care and treatment they received within the service and we saw that patients were treated with compassion, dignity and respect.

Compassionate care

- We saw that patients were treated with compassion, and their dignity and privacy was respected.
- We observed positive interactions between patients and nursing staff. We saw that nurses were responsive to the individual needs of patients undergoing a surgical termination.
- Patients were asked how they wished to be addressed and their preferred names were recorded.
- Discussions were held with patients regarding the disposal arrangements for fetal tissue. Patient's wishes were respected and their beliefs and faith were taken into consideration.
- Patients we spoke with were positive about the way they had been treated by staff.
- Views from the recently introduced patient feedback system were positive. Quotes included "I think the care was excellent," "The best care I have received on the NHS" and "The waiting time was longer than I expected but everyone was lovely and extremely friendly."

Understanding and involvement of patients and those close to them

- Notices displayed in treatment rooms informed patients they could request a chaperone to be present during consultations and examinations.
- Patients were involved in their care. Women were given the option to insert their own pessaries (a pessary is medication that is inserted directly into the vagina or cervix) and they were given instructions on how to do this.
- The records we saw considered and recorded the post discharge support available for patients at home. This ensured that they were not discharged home alone.
- Incident records showed that there were occasions when patients changed their minds about terminating their pregnancy. Staff we spoke with told us that in these circumstances the patients were referred for scans and antenatal care.

Emotional support

- Patients considering termination of pregnancy should have access to pre-termination counselling. The policy in use at the treatment centre stated that patients were provided with pre termination counselling sessions by the referring services as well as by staff who were working at the treatment centre. These staff were employed by another NHS organisation but worked at the treatment centre. Two patients we spoke with told us they had not been offered or received counselling prior to their termination.
- The service had audited the records of patients who had undergone a termination of pregnancy. In December 2014, the notes of eight patients were audited. The audit indicated that no counselling was recorded in five of the records, one set of records had no answer recorded and two of the patients had received counselling. The January 2015 audit showed that in five out of seven sets of records it was recorded that there was no evidence of counselling being discussed.
- Where patients had declined counselling this was respected and recorded.

Termination of pregnancy

Are termination of pregnancy services responsive?

Requires improvement

Overall we found the responsiveness of the termination of pregnancy service required improvement

The centre provided only part of the care pathway for the termination of pregnancy so some aspects of care delivery lay with other providers. There was not always timely access for patients to undergo procedures. Department of Health Required Standard Operating Procedures indicate that there should be a 10 working day referral to procedure process. This was not always being achieved and there was no analysis to establish why. Where patients were near to 14 week gestation there were systems to fast track procedures to limit the future risk to their health.

Staff understood the needs of patients and were able to meet their individual needs. There were systems in place to inform patients how to raise concerns.

Service planning and delivery to meet the needs of local people

- Where women were nearing the 14-week gestational stage a fast track appointment system was in place as this was the latest that a surgical termination could be carried out at the Treatment Centre.
- Protected theatre times to offer 20 procedures per week were made available. These were ring fenced to ensure that procedures could be scheduled at short notice.
- Scheduling for surgical procedures was booked by referrers into planned appointment slots and there were systems in place to allocate additional theatre slots if this was required.

Access and flow

- The centre did not undertake all aspects of the termination of pregnancy care pathway. Patients were referred from two other local providers. These providers undertook all the date checking scans to confirm pregnancy. Some pre- termination assessments were completed at the centre but most were completed by the referring providers.
- Department of Health guidelines state the referral to procedure time should be no longer than five days in order that patients get timely access to terminations. Information from the centre showed that this was not always being achieved. The waiting time for procedures were monitored, these showed wide variance from one to 30 days. The sooner a procedure is completed the lower the risk to the patients' health and guidance states the total time from access to procedure should not exceed ten working days. Data we reviewed showed that of 627 procedures during 2014 there were 133 which did not meet the 10 day timescale. There were no reasons recorded to explain why targets were not met. Some of these delays could have been down to patient choice but this could not be established.

Meeting people's individual needs

- The centre was accessible to wheelchairs users, with lifts and disabled toilets being available.
- A telephone translation service was available to enable staff to communicate with patients. Where it was known that translators were required, these were bookable. Staff told us they did not use the telephone translation service where they were obtaining consent from patients. Instead a translator would be used to gain consent and ensure the patient understood and could weigh up the decision to continue.
- Where a translator had been used as part of the consent consultation there was space on the consent form for the interpreter to sign to confirm they had interpreted to the best of their ability and they considered the patient has understood.
- A portable loop system was available to improve communication with patients who used hearing aids.

Learning from complaints and concerns

- Staff told us that if patients raised concerns they tried to resolve these at the earliest opportunity.
- At each reception desk, there were leaflets which informed patients how to raise concerns but some details such as telephone numbers were not correct on these. We alerted the provider to this during our visit.
- There were no recorded complaints in the past 12 months about the termination of pregnancy service.

Are termination of pregnancy services well-led?

Termination of pregnancy

Requires improvement

The leadership in the termination of pregnancy service required improvement. We found the service was managed in a fragmented manner and this meant the team was not cohesive and lacked a team identity. There were some systems in place to monitor the quality of the service but there was insufficient action being taken to improve the quality of the service offered. Staff worked in isolation with there being a lack of opportunity to meet or develop the service.

Staff displayed an enthusiastic, compassionate and caring manner to the care they delivered. There were systems in place to consult with staff.

Vision and strategy for this service

- The treatment centre had their own 'credo.' This described their purpose, parameters and principles for healthcare provision. Staff knew about the credo and it was embedded throughout the centre. However there was no clear vision and strategy for termination of pregnancy services.

Governance, risk management and quality measurement

- There was some monitoring of the quality of the service taking place but there was insufficient action being taken to address any deficits.
- There was little analysis of performance information. The service collated referral to treatment time (RTT) statistics but did not review or analyse them in order to improve services. Although the service did not consistently meet the target, there were no action plans in place to minimise delays in treatment.
- Monthly audits of a sample of records were completed; this was approximately a 10% sample of the procedures undertaken each month. We reviewed three monthly audits between October 2014 and January 2015. Two of the three audits were incomplete as there were some gaps.
- The audits showed that in some areas, for example counselling, and the rhesus status of patients, the required standard operating procedures were not being met. There were no action plans available to address the findings of the audits.
- A quality improvement plan had been developed in January 2015. This referred to the required standard operating procedures. As this had just been put in place at the time of our inspection it was too early to assess its effectiveness.

Leadership of service

- The termination of pregnancy service was managed as part of the wider gynaecology service. The service lacked a clear identity or sense that staff were part of a dedicated termination of pregnancy team. Some staff worked in isolation and told us they did not have the opportunity to attend team meetings or development days.
- The staff who made up the termination of pregnancy service came from a range of sources – some were employed by the centre, some worked under practising privileges on a sessional basis and others worked under service level agreements from another NHS trust on a sessional basis. This meant there was a fragmented staff group, each dedicated to their part of the care pathway but working in isolation. The team never met together as a group and there was no cohesiveness or team identity as each staff member worked within their own separate area.

Culture within the service

- Staff displayed an enthusiastic, compassionate and caring manner to the care they delivered. They recognised that it was a difficult decision for patients to seek and undergo a termination of pregnancy.
- Staff told us morale within the treatment centre was good. They told us about the benefits they received such as a monthly massage and fresh fruit being available each morning.
- Staff told us they felt they could openly approach managers if they felt the need to seek advice and support. For sessional staff their supervision was provided by their substantive managers but they told us they could approach staff at the centre if they needed to.

Public and staff engagement

- Most patients attending the centre were given forms or an electronic feedback form which asked for their opinion of the service. Staff told us that feedback was not actively sought from patients who had undergone a termination of pregnancy. At our initial visit we were told

that this was due to the procedure being a sensitive and potentially emotional experience for patients. At our second unannounced visit specific feedback cards had been introduced and were being used to gain patients views. These asked one question, "Has the care you received been compassionate," and provided space for written feedback. Some cards had already been received and all were positive.

- Staff surveys were completed to gain staff opinion of working at the centre.
- Some staff, through personal choice, did not take part in the termination of pregnancy procedures. This demonstrates there was respect and regard for the personal beliefs of staff.
- "Partnership" development days were held for staff. There was confusion about whether sessional staff had been invited as the managers thought they had but the staff we spoke to said they had not been invited.
- There were no dedicated staff meetings for staff involved in the termination of pregnancy service.

Innovation, improvement and sustainability

- The service was sustainable. The centre was commissioned to provide the termination of pregnancy service by the Clinical Commissioning Group. There was dedicated surgical time allocated, with provision for this to be increased if demand increased.

Outstanding practice and areas for improvement

Outstanding practice

- The treatment centre was piloting the implementation of a care certificate for healthcare assistants (HCA's) achieved through a HCA training programme which offered specialty training and skills development.
- The centre had an initiative called 'Stop the Line.' Any member of staff could stop activity if they felt patient safety may have been compromised. When "Stop the line" was triggered, there was immediate escalation of the issue and a resolution was developed immediately. All the staff we spoke with were enthusiastic about this initiative and were able to give examples of where they had used 'Stop the line.' The examples they gave demonstrated staff felt confident to use the process and most importantly that action was taken to respond to concerns. The treatment centre used a process called "Swarm." Staff at different levels attended a meeting following a stop the line which was designed to assess the risk and put immediate control measures in place to reduce the risks. We saw evidence of this being used in practice.
- The treatment centre undertook a 28 day post-operative call to patients to monitor clinical outcome data that included surgical site infections. This patient self-reported data was shared with the commissioners of the service. Information received following our inspection indicated a decline in surgical site infections, with 13 reported in November 2014; nine reported in December 2014 and; three reported in January 2015.

Areas for improvement

Action the hospital MUST take to improve

- Ensure medication administration records within the termination of pregnancy service are clearly legible and written in accordance with GMC guidance, "Good practice in prescribing and managing medicines and devices."
- Ensure the prescribing of Anti-D immunoglobulin medication within the termination of pregnancy service only takes place when it has been established that it is a clinically suitable treatment for the patient.

Action the hospital SHOULD take to improve

- Ensure complaints are managed in accordance with the treatment centre policy so that patients have up to date information about how they can access the support of complaints advocacy services.
- Ensure there is timely access to termination of pregnancy procedures, which should meet Department of Health required standard operating procedures (RSOP11 – access to timely abortions).
- Ensure the governance and leadership in the termination of pregnancy service is strengthened to ensure there is effective monitoring and response to the findings of audits.
- Ensure there is a system for checking the accuracy of HAS4 forms used in the termination of pregnancy service to ensure that accurate information is provided to the Department of Health.
- Ensure systems are developed so that sessional staff working in the termination of pregnancy service receive feedback and learning from incidents.
- Ensure a review of the risks associated with the use of the lifting and handling equipment within the imaging department takes place so that patients who have mobility difficulties can be safely assisted onto the imaging beds.
- Consider introducing team development initiatives within the termination of pregnancy service to enable cohesive working practices.
- Consider working with partner providers and commissioners of termination of pregnancy services to ensure the patients care pathway is one which meets required standards.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Termination of pregnancies	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing , safe administration and disposal of medicines used for the purposes of the regulated activity. People who use services were not protected against the risks associated with unsafe use and management of medicines because the prescribing of Anti-D immunoglobulin medication took place when it had not been established that it was a clinically suitable treatment for the patient. Medication administration records were not clearly legible and written in accordance with GMC guidance, “Good practice in prescribing and managing medicines and devices.” Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010