Day Surgery Unit

Quality Report

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

The Day Surgery Unit is operated by Day Case UK LLP. It is a partnership between Yeovil District Hospital NHS Foundation Trust and Ambulatory Surgery International. Facilities include two operating theatres, a recovery suite, a ward area with seven patient cubicles and an endoscopy unit. The service is operational over five days from 8am to 6pm with occasional planned endoscopy lists on Saturdays as required.

The service offers day surgery procedures in cardiology, dermatology, ear/ nose and throat (ENT), general surgery including some laparoscopic (keyhole) procedures, oral and dental procedures, ophthalmology, orthopaedics, plastic surgery and urology (function of and disorders of the urinary system).

This was our first inspection of the Day Surgery Unit since it was registered with the Care Quality Commission (CQC) in March 2017. We inspected this service using our comprehensive inspection methodology. Please note that in this report, some dates refer to data provided for February 2017. The service was run by Yeovil District Hospital in that month, and Day Case UK LLP from March 2017.

We carried out the announced part of the inspection on 23 and 24 May 2018, followed by an unannounced visit to the hospital on 6 June 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We rated this service as good overall because:

- Staff received mandatory training including safeguarding training, to the appropriate level relevant to their role and responsibilities.
- There was a good safety track record.
- There were systems and processes to ensure the safe use and maintenance of equipment.
- Risk assessments, in line with national guidance, were used to keep patients safe.
- There were adequate nursing staff levels to safely meet the needs of patients.
- Patient care records were written and managed in a way that protected people from avoidable harm.
- Medicines prescribing and administration were safe and in accordance with local policy.
- Staff were open, transparent and honest about reporting incidents.
- Staff had access to policies, standard operating procedures and guidelines reflecting evidence-based care and treatment, which had been developed in line with national guidance.
- Staff monitored patients for signs of pain and ensured additional pain relief was administered if required.
- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- There were effective processes for obtaining valid consent.
- Staff showed an encouraging, sensitive and supportive attitude to patients and their relatives.
- We observed caring, respectful and compassionate interactions between staff and patients and their relatives.
- Services were planned and delivered in a way that met the needs of the local population.
- Services were planned, coordinated and delivered to consider patients with complex needs to optimise care, treatment and access to services.
- The service had policies and processes to appropriately investigate, monitor and evaluate complaints.
- The leadership team of the service had the skills, knowledge and integrity to lead the service.
- There was a culture of openness, candour and honesty amongst staff.

Summary of findings

- Staff felt valued and empowered to suggest and be involved with service improvement initiatives.
- There were effective governance structures to monitor performance, risks and outcomes to provide safe, good quality care.
- Governance and risk management processes were fit for purpose.
- There were systems and arrangements to identify, record and manage risks.
- There were systems to engage with patients and the public to ensure regular feedback on services.
- There was a clear focus on looking for potential innovative solutions to continue to ensure the delivery of high quality care.

However, we found areas of practice that require improvement:

- Staff did not always comply with infection prevention and control standards.
- Training compliance for dementia awareness, Mental Capacity Act and Deprivation of Liberty Safeguards did not meet local target.
- The full attention of staff was not always given during the 'sign out' stage of the 'five steps to safer surgery' checklist.
- Patient records were not stored to provide confidentiality when staff admitted children and young people on the paediatric ward.
- Staff did not always follow national guidance for the receipt of controlled medicines.
- There was no standardised template for incident investigations.
- There was limited data collected and reviewed to allow for comparison against similar services nationally.
- Comfort scores for patients receiving endoscopy procedures were not always completed in line with national guidance.
- There was no effective audit process to show how many patients were admitted to the local NHS trust after their procedure because of complications.
- The processes to identify patients' communication needs were limited. This meant the service was not fully compliant with the Accessible Information Standards. These standards became obligatory in 2016 for all NHS care providers.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements even though a regulation had not been breached, to help the service improve.

Amanda Stanford
Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	We rated this service as good because it was effective, caring, responsive and well-led, although it required improvement for safety.

Summary of findings

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Good

Day Surgery Unit

Services we looked at

Surgery

Summary of this inspection

Background to Day Surgery Unit

The Day Surgery Unit is operated by Day Case UK LLP. The service opened in March 2017. It is situated within Yeovil District Hospital in Somerset. The NHS trust and the Day Surgery Unit work as a partnership to provide day-case surgical and endoscopy procedures to NHS patients. The service primarily serves the communities of the Yeovil, Somerset and Dorset. It also accepts patient referrals from outside this area.

The service has had a registered manager – Mrs Yvonne Thorne - in post since it was registered in March 2017. The service is registered to provide the following regulated activities:

Diagnostics and screening procedures.

Surgical procedures.

Treatment of disease, disorder and injury.

The service provides day surgery procedures in cardiology, dermatology, ear/ nose and throat (ENT), general surgery including some laparoscopic (keyhole) procedures, oral and dental, ophthalmology, orthopaedics, plastics, urology and endoscopy procedures.

Our inspection team

The team inspecting the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in surgery. The inspection team was overseen by Mary Cridge, Head of Hospital Inspections, South West and Alison Giles, Inspection Manager South West.

Information about Day Surgery Unit

Day Case UK LLP provides day surgery at two different locations. The main unit is the Day Surgery Unit at Yeovil District Hospital situated within the main hospital building. The other location is the Castleton Day Unit in leased premises in an NHS community hospital in Sherborne, Dorset. We inspected both locations and we have written a separate report for each location although much information and data is shared. Wherever possible we have reported on data or information specific to the two separate locations.

We carried out the announced part of the inspection on 23 and 24 May 2018 and an unannounced visit on 6 June 2018.

During the inspection, we visited the day surgery theatres, the ward area, the recovery area and the endoscopy unit. We spoke with 32 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with six patients and two relatives. We also received 30 'tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed seven sets of patient records.

There were no special reviews or investigations of the organisation ongoing by the CQC at any time during the 12 months prior to this inspection. This was the services first inspection since registration with CQC.

Activity (February 2017 to January 2018):

The service carried out 8,647 day surgery procedures and 5,842 endoscopy procedures. Most procedures (90%) were carried out for adults over the age of 18 with the remaining 10% (410 patients) being children and young people under the age of 18 years. Most of the procedures (98%), were NHS-funded and the remaining 2% were privately funded. The service also carried out procedures for inpatients of the local NHS hospital, including endoscopies. From January to December 2017, the service treated 291 inpatients of the local NHS hospital.

Summary of this inspection

Staffing on 1 February 2018 consisted of 20.4 whole time equivalent (WTE) registered nurses, 9.9 WTE operating department practitioners and health care assistants and 12.6 WTE other hospital staff. Staff were employed to work across both locations. Medical staff were not employed by the service but worked as part of a contract with the local NHS trust.

There was a registered manager of the service, who had been in post since the service opened in March 2017.

The accountable officer for controlled drugs (CDs) was the chief pharmacist at the local NHS trust.

Track record on safety during the period from January to December 2017:

- No never events.
- 20 clinical incidents (12 low harm, 8 moderate harm).
- 148 non-clinical incidents.
- No incidences of hospital acquired MRSA.
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus.
- No incidences of hospital acquired Clostridium difficile (c. diff).
- No incidences of hospital acquired E-Coli.
- The service had received one complaint since it opened in March 2017.

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAGS) accreditation: unit number ENG/143, Certificate number JAGWEB/300, date certified 05/02/2018.

The service worked closely with the local NHS trust who provided a range of services under service level agreements (SLA). These included:

- Medical staff.
- Dental staff.
- Pharmacy and medicines.
- Blood products.
- Imagining.
- Pathology.
- Insurance, clinical coding, finance, clinical governance, infection control, medical records, risk management, human resources and payroll, marketing and communications, non-clinical theatre support, patient pathway administration and referral to treatment.
- Fire, health and safety.
- Housekeeping and domestic services.
- Estates maintenance.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Compliance with mandatory training mostly met local targets. Staff received safeguarding training to the appropriate level for their roles and responsibilities. However, compliance with dementia awareness training, Mental Capacity Act and Deprivation of Liberty Safeguards was 64% against a local target of 80%.
- Staff did not always comply with infection prevention and control standards. Compliance with the five moments of hand hygiene was below local target. Not all staff were bare below the elbow when working in the operating theatre and ward area. This was not in accordance with national guidance.
- The service did not have an overview of cleaning audits to ensure good practice and a clean the environment.
- There was limited space in the recovery area, which could compromise easy access to patients in clinical emergencies.
- Theatre safety checklists were not always completed at the end of the day.
- Staff did not always give their full attention during the 'sign out' stage of the 'five steps to safer surgery' checklist. This meant questions had to be repeated and there was a risk faulty equipment was not followed up.
- Patient records were not stored confidentially when staff admitted children and young people on the paediatric ward. This meant unauthorised people could have access to confidential records about patients.
- Staff did not always follow national guidance for the receipt of controlled medicines, which meant there was an incomplete audit trail for the safe management of controlled medicines.
- There was no standardised template for incident investigations.
- Comfort scores for patients receiving endoscopy procedures were not always completed in line with national guidance.
- There was no effective audit process to provide an overview of how many patients were admitted to the local NHS trust after their procedure because of complications.

However, we also found examples of good practice:

- There was a good safety track record. There had been no serious incidents in the 12 months prior to the inspection. The service reported there had been no hospital acquired infections since the service opened in March 2017.

Summary of this inspection

- Staff received safeguarding training at a level relevant to their role and responsibilities.
- There were systems and processes to ensure the safe use and maintenance of equipment. Staff completed operating theatre checklists and checked emergency equipment. This ensured equipment was working as it should be and emergency equipment was available if it was needed.
- Medicines prescribing and administration were safe and in accordance with local policy.
- There were adequate nursing staff levels to safely meet the needs of patients.
- Patient care records were written and managed in a way that protected people from avoidable harm. There were effective processes to ensure safe discharge of patients following day case procedures.
- Staff were open, transparent and honest about reporting incidents. There were systems to make sure incidents were reported and investigated appropriately. Staff received feedback and there were processes to ensure learning from incidents were shared with all relevant staff.
- Staff attended a safety 'huddle' before the morning procedure list started. This provided an opportunity for staff to discuss the day's activity and any issues relating to staffing or equipment concerns.

Are services effective?

Good

We rated effective as good because:

- Staff had access to policies, standard operating standards and guidelines reflecting evidence based care and treatment, which had been developed in line with national guidance.
- Regular internal audits were carried out to monitor performance and to maintain standards.
- Staff monitored patients for signs of pain and ensured additional analgesia was administered if required.
- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients. Staff were encouraged to develop their knowledge and skills to improve the quality of care provided.
- There were processes for obtaining valid consent. There was a policy for consent for examination or treatment, which included procedures that enabled health care professionals to comply with consent guidance.

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

Summary of this inspection

- There was limited data collected and reviewed to allow for comparison of outcomes for patients against similar services nationally.

Are services caring?

Good

We rated caring as good because:

- Staff showed an encouraging, sensitive and supportive attitude to patients and their relatives.
- We observed all staff taking time to talk to patients in an appropriate manner.
- We observed caring, respectful and compassionate interactions between staff and patients and their relatives.
- Patients and their relatives we met spoke highly of the service they received.
- We observed good attention from all staff to patients' privacy and dignity.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered in a way that met the needs of the local population. The service worked with the local NHS trust and other stakeholders including GPs, to meet the needs of the local population.
- Services were planned, coordinated and delivered to consider patients with complex needs to optimise care, treatment and access to services.
- Staff used technology to monitor and thus enhance the efficiency of the delivery of care and treatment. An electronic system was used to capture data about how well the services were operating.
- The service had policies and processes to investigate, monitor and evaluate complaints. There had only been one complaint about care since the service opened in March 2017.

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

- The processes to identify patients' communication needs were limited. This meant the service was not fully compliant with the Accessible Information Standards. These standards became obligatory in 2016 for all NHS care providers.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- The leadership team of the service had the skills, knowledge and integrity to lead the service.
- There was a culture of openness, candour and honesty amongst staff.
- Staff felt valued and empowered to suggest and be involved with service improvement initiatives.
- Staff felt able to raise concerns internally and knew how to do so.
- There were effective governance structures to monitor performance, risks and outcomes to provide safe, good quality care.
- Governance and risk management processes were fit for purpose. They were part of the positive working relationship between all staff teams and the management team.
- There were systems and arrangements to identify, record and manage risks.
- Information was shared effectively with staff through a variety of ways.
- Information to deliver effective care was readily available.
- There were systems to engage with patients and the public to ensure regular feedback on services.
- There was a clear focus on looking for potential innovative solutions to continue and improve the delivery of good quality care.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Requires improvement

We rated safe as requires improvement.

Mandatory training

Staff received a programme of mandatory training and regular updates. This was delivered to all staff through a service level agreement with the local NHS trust. Mandatory training included fire safety, moving and handling, safeguarding, infection control and prevention and basic life support. In addition, staff were required to complete regular updates in essential training modules such as medicine management and mentoring. Overall training compliance was 98% at the time of our inspection.

Training compliance was monitored at the end of each month and records were cross-referenced with those held by the academy from the local NHS trust to ensure accuracy. A report was submitted to the management information team. Records demonstrated staff were up to date with mandatory and essential training (additional service specific training) and updates or were booked onto courses. When new equipment was introduced into the clinical areas, this was accompanied by training for the staff using it.

Compliance with training and regular updates for dementia training, Mental Capacity Act and Deprivation of Liberty Safeguards training and regular updates was below local targets. Training records demonstrated 64% of staff were compliant with training and regular updates against a target of 80%. However, an update had been provided for staff during a monthly clinical governance session.

All registered nursing staff had immediate life support skills and received updates every year. The theatre manager also held the advanced life support qualification. All recovery and anaesthetics staff held a paediatric life support certificate or were booked to receive their annual update.

There were processes to monitor mandatory training compliance for medical staff including consultants, working in the Day Surgery Unit. Medical staff were employed by the local NHS trust who provided their mandatory training and updates. Information about medical staffs' clinical practice, mandatory training compliance and appraisals were discussed monthly at the board meeting. The registered manager was kept informed of when medical staff were due to update their mandatory training and followed this up with the NHS trust.

Safeguarding

There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. There was a contractual agreement with the local NHS trust to access full safeguarding services from the trust's integrated safeguarding team. There was a policy aimed at ensuring all staff could identify potential cases of abuse, protect adults at risk and all children from abuse and/or exploitation, female genital mutilation and human trafficking.

Staff were knowledgeable about the safeguarding policy and processes. They were clear about their responsibilities and described what actions they would take should they have safeguarding concerns about a patient. Safeguarding concerns were reported to the registered manager and the safeguarding team from the local NHS trust, using an electronic incident reporting system for appropriate action.

Staff received safeguarding training to the appropriate level relevant to their role and responsibilities. Safeguarding training was delivered during induction and as part of mandatory training provision to meet requirements for regular updates. All staff received level two child protection training and adult safeguarding. Senior nurses received level three adult safeguarding training to ensure they could support junior staff if required.

There was 24-hour access to someone who was Level 3 trained. During in-hours, the registered manager and staff on children's ward level 10 were available. Those on the ward were the matron and all sisters, and theatre and anaesthetic / recovery leads. Out of hours, the on-call paediatric team and ward level 10 staff were available.

In addition the service employed a part time paediatric nurse, who was rostered to work on the days there were planned procedures for children and young people under 18 years of age. This member of staff received child protection training at level three.

The service was assured there was effective cover for child safeguarding at all times.

Training records demonstrated staff were up-to-date with their training or were booked onto a training course to ensure timely compliance.

Patients had access to a chaperone if required. The service had a chaperone policy, which provided guidance for staff including specific advice about issues such as religious, ethnical or cultural considerations. There were posters in the waiting room and around the unit inviting patients to ask for a chaperone. Staff told us medical staff asked nursing staff to chaperone if they were required to carry out intimate examinations. Healthcare assistants received chaperone training to enable them to act as chaperones. However, staff did not always document when they had offered to act as a chaperone or when they had acted as a chaperone for patients. This was not in line with national guidance (General Medical Council 2013).

Cleanliness, infection control and hygiene

There were systems to monitor and prevent the spread of infection within the unit. There was an infection prevention policy, which detailed the mechanisms for effective management of infection prevention and control.

There were no reported incidents of healthcare-associated infections such as MRSA, Clostridium difficile (C. diff), Methicillin-sensitive Staphylococcus aureus (MSSA) or E. Coli in the past 12 months.

There were no surgical site infections reported between June 2017 and January 2018 (the data was not available prior to this date range). Management staff at the unit told us there was no information available specific to the service within the data provided by the NHS trust. This was because GPs did not routinely report to the hospital if patients attended with post procedure complications.

There was a policy for the detection and management of MRSA. The policy outlined the responsibilities of staff and provided guidance about which patients should be screened for MRSA prior to attending for day surgery or endoscopy procedures. Staff told us all patients attending for procedures carried out under general anaesthesia were screened as part of pre-operative assessment carried out by the local NHS trust. Staff told us if pre-procedure MRSA screening was not completed, they would inform the consultant surgeon so a decision could be made regarding continuing with the planned patient procedure. Staff would also complete an incident form. We were told there were no incidents about screening failure reported from March 2017 to and including May 2018.

The unit was used to accommodate patients from the local NHS trust at times of operational winter pressures. These patients were not routinely screened for MRSA before being admitted to the area. This meant there was a risk some patients could be admitted to the unit without staff having prior knowledge of potential infection risk. To mitigate this potential risk staff were required to adhere to strict infection control measures to prevent the spread potential infection. There had been no incidences of MRSA since the unit opened in March 2017.

Staff adhered to national guidance for prevention of surgical site infections. Patients received information about showering on the day of surgery before attending the unit. Staff wore appropriate theatre wear and used recommended processes during the procedure to minimise the risk of infection. For example, we observed staff clean the patient's skin with recommended skin cleansing agents prior to surgery and monitoring of patients during the surgical procedure. We observed staff discuss suitable

dressings and follow-up arrangements. Staff discussed with patients how to care for the wound including dressing changes, signs, and symptoms of infection, before they were discharged from the service.

The service had processes to dispose of clinical waste securely. Staff used ready prepared packs containing sterile equipment such as drapes and instruments, which were all single use. These were disposed of following surgery in appropriate waste bags/containers for clinical waste. Waste was taken out from the operating theatre to an adjacent 'dirty' sluice where porters collected the sealed waste bins and containers. Used equipment that needed to be decontaminated and sterilised before it could be used again, was removed from theatre and packaged to be collected by staff from the local NHS trust's sterilisation services department. There were systems to ensure separate pathways for clean and used equipment to prevent contamination. Sharps bins were observed to be temporarily closed when not in use; they were not overfilled and were labelled and dated.

There were processes to ensure scopes used for endoscopy procedures were cleaned and decontaminated in line with national guidance. The endoscopy service used the sterile services department (SSD) at the local NHS trust for decontamination and cleaning of all scopes. Clean scopes were received in specific trolleys for each endoscopy procedure room. The clean scopes were clearly marked with an expiry time to ensure they were used within three hours of decontamination/cleaning in line with national guidance. Staff removed used scopes by a different entrance to the endoscopy procedure room. Used scopes were stored in closed trolleys until they were returned to the sterile services department for decontamination and cleaning. Staff completed appropriate documentation to ensure all reusable equipment could be traced in case of any issues occurring. Water testing was undertaken by the SDD department and staff felt confident they would be notified if there were any issues.

Staff demonstrated good hand hygiene practices. We observed clinical staff, including doctors, nursing staff, operating department practitioners and healthcare assistants washing their hands and using anti-bacterial gel in line with infection prevention and control guidelines. Non-clinical staff including reception, administrative staff and cleaning staff were also observed to follow guidelines. There were hand hygiene stations and alcohol hand gel was readily available around the unit. Provision of scrub area facilities (a dedicated scrubbing area for surgeons and operating theatre staff to carry out extensive hand hygiene procedures prior to surgery) were in line with national guidance.

Staff used personal protective equipment such as gloves and aprons as required and disposed of these safely in bins for clinical waste. Theatre staff wore recommended theatre wear such as scrub uniforms, rubber shoes, surgical hats and masks. Surgeons and scrub nurses completed thorough 'scrub preparation' in accordance with national guidance. However, not all staff were bare below the elbow when working on in the operating theatre and ward area. We observed some staff (who were not operating) wearing theatre jackets with long sleeves when assisting with the positioning of patients. We observed staff in the ward area wearing long sleeved 'theatre jackets' while they were providing care for patients. We brought this to the attention of the registered manager when we returned for an unannounced visit on 6 June 2018. They stated they would take immediate action to ensure compliance by all staff to be bare below the elbow.

The service undertook regular monthly hand hygiene audits. The audit was designed to capture staff compliance with national guidance: five moments for hand hygiene (World Health Organisation (WHO), 2009). The audit looked at overall compliance, compliance by each 'moment' and for different staff groups (medical staff and nurses). The overall compliance with all five moments of hand hygiene was based on 1,305 observations between August 2017 and end of January 2018. The result demonstrated between 84% and 96% compliance against a target of 90%, which was met in three of the six months.

All surgical, endoscopy and ward areas were visibly clean. Equipment was visibly clean and we saw green 'I am clean' labels placed on trolleys and equipment that had been cleaned and were ready for use. The service used fabric curtains to separate patient cubicles and patient trolleys in the recovery area. These curtains were changed every four months or sooner if required. Staff kept a log of when the curtains were changed. Furniture and fittings were made of materials easy to clean, disinfect and maintain. Staff reported a good standard of cleanliness and when speaking to patients everyone commented on the cleanliness of the unit.

There was a dedicated team of cleaners from the local NHS trust, who ensured the areas were cleaned regularly. There were cleaning checklists to ensure the ward and theatre departments were cleaned regularly. The ward and theatres were cleaned in the evening with toilets cleaned and bins emptied at lunchtime and again in the evening. The team would clean at other times if required. We were told cleaning audits were carried out monthly by the cleaning supervisor working for the local NHS trust. However, audit results were only available for March 2018, although these demonstrated 100% compliance. The manager of the service told us they were working to obtain more regular results in future.

There was an associated environmental audit action plan for maintenance work such as 'paint touch up' of walls. The registered manager confirmed these had all been completed. However, we observed paper-based information displayed in different areas, which was not laminated. This could pose an infection risk as dust could collect and could be difficult to clean.

There were processes to reduce risks associated with communicable infections for patients attending for endoscopy procedures. Staff planned for patients with possible or confirmed communicable infections to be treated at the end of the day. Staff looked after patients in areas away from other patients and there were systems to ensure appropriate deep cleaning procedures were carried out after treatment and recovery.

Environment and equipment

The design of the Day Surgery Unit kept people safe. The unit had adequate security systems to protect patients and staff. This included swipe card access to locked areas. Staff said they felt safe in their working environment. The unit had its own reception area and waiting room. There was secure access to the ward area to prevent unauthorised people entering the unit.

There were four consulting rooms, a ward area with seven patient cubicles, two operating theatres, two endoscopy rooms and a recovery area. The decoration and flooring were intact. There was a kitchen area for staff to prepare refreshments for patients following their surgery or procedure. There were clean and dirty utility rooms to ensure dirty equipment and waste were separated from clean and sterile equipment. There were offices for managers to work from and a small staff room for staff, which staff described as a very confined space.

Fire safety was managed effectively. We saw a report from January 2018, which set out the evacuation plan for the Day Surgery Unit. The plan set out the roles and responsibilities of staff. Fire exit routes were clearly marked and free of permanent obstacles although some portable equipment was stored in the corridors. Fire extinguishers and fire blankets were in date of their annual checks.

Some areas had not been risk assessed, although the service had recognised the environment was not ideal. There was no risk assessment carried out about the lack of space, which was of particular concern in the recovery area. There was insufficient space between trolleys to ensure easy access in case of clinical emergencies. Medical staff told us the space was constrained and this was particularly an issue if multiple specific and long operations were scheduled on the same list. These patients needed a longer first-stage recovery period, which meant capacity was reduced in the recovery area. Staff said they worked around space problems and were creative in finding solutions. Following the inspection, we were informed there were plans to risk assess the space in the recovery area with support from resuscitation leads from the local NHS trust.

The design of the facilities met guidance set out by the Association of Anaesthetist of Great Britain and Ireland (AABGI). There was an anaesthetic room for each of the operating theatres. This room was large enough for clinicians to carry out pre-operative procedures such as general anaesthesia. One anaesthetic room was used for children and had child-friendly laminated pictures of animals on walls and on the ceiling. Staff told us these pictures helped them distract children and stated many adults commented positively on the many pictures. Appropriate equipment was available for children in the anaesthetic room such as paediatric airway support and difficult airway management equipment.

There were scrub and gowning rooms for surgeons and scrub nurses for preparation to undertake sterile procedures. These were large enough for two people to scrub at the same time using recommended sinks and hands-free operated taps. There was a preparation room

for each theatre, where staff could prepare the sterile equipment used during the operation. This ensured staff could prepare equipment safely without accidental contamination of sterile equipment laid up on trolleys.

There were gender specific changing areas for patients attending for endoscopy procedures. There was a separate lounge for patients to complete their second stage recovery before discharge, enjoy refreshments and receive discharge summaries. There was a separate quiet room available if discussions about outcomes and onward referral for treatment was required. Patients' personal belongings were kept in baskets and followed each patient through the department.

There were systems to ensure the safe use, maintenance and replacement of equipment. Staff checked emergency and surgical equipment daily. We checked the resuscitation trolley and found randomly chosen consumables and medicines to be stored in unbroken packaging and within date. The trolley was tamper evident, and staff recorded the number of the tag to ensure it had not been replaced through unauthorised access. We reviewed the checklists between 15 March and 22 May 2018, which confirmed the resuscitation trolley was checked every day the unit was open.

We saw a range of equipment was readily available and staff said they had access to the equipment they needed for the care and treatment of patients. Specialised equipment was ordered in advance in line with the standard operating protocol. There was an agreement to share equipment with the main operating department at the local NHS trust. This meant the order of operating lists often had to be changed to allow equipment to be available from the main theatre operating department. Staff stated this was not ideal, but it was managed well due to the close working relationship with the local NHS trust.

Staff had access to manual handling equipment including glide sheets, slides and hoists. Staff received regular manual handling training.

Equipment was maintained and serviced regularly. We reviewed a random sample of equipment in the store room and across the theatres, ward and endoscopy treatment rooms and labels confirmed the equipment had been serviced within the last 12 months. The service kept an asset register, which was managed by the local NHS trust as part of a service level agreement. This showed details of the device and service completion date and regularity.

Most, but not all theatre safety checklists were completed. There were daily theatre safety checklists for staff to complete and the anaesthetist checked the anaesthetic machine prior to use. Nursing staff were required to carry out theatre cleaning and checklists at the beginning and the end of the day. We looked at records of these checks for theatre two. We found the end of the day checks had not been completed on 6, 8 and 9 March and 4 May 2018. This meant, for example, there was no documented assurance the operating tabled was plugged in overnight as required, that all specimens had been sent for further investigation, and the theatre debriefing for staff had been completed.

Ward equipment was checked as required. Staff checked equipment on the ward daily and we saw records of this. Checks included suction, oxygen, nasal prongs, call bells, bed and brakes and gel dispensers. Regular stock takes were completed and included checking of expiry dates and ensuring appropriate stock rotation. We randomly checked some consumables and found these were stored in unbroken packaging and within expiry date.

There were guidelines for 'the use of X-rays in theatre' from the local NHS trust, which staff followed. The service accessed radiology through a service level agreement with the local NHS trust. Trained and competent radiologists only used radiology and all other staff acted under their instructions. For example, staff were directed to follow instructions about positioning or personal protection such as lead aprons.

Assessing and responding to patient risk

Risk assessments were used to keep patients safe and were in line with national guidance. Staff completed patient risk assessments when admitting adult patients for day surgery or endoscopy procedures. Information was gathered from and about the patient to ensure, all risks were assessed and managed. Patients attending for day surgery procedures had attended a pre-operative assessment in an outpatient clinic prior to their day surgery. There was a day case surgery selection criteria checklist designed to ensure

patients were suitable for day surgery. The criteria included an assessment to ensure patients were medically suitable, had somebody to look after them and that the proposed surgical procedure was suitable for day case surgery.

Anaesthetists assessed the risk of general anaesthesia for patients. The service recognised the American Society of Anaesthesiologists (ASA) physical status classification system to describe a person's fitness to be given anaesthesia for a procedure. Patients were only accepted if their ASA grade was grade one or grade two, which classified patients as being healthy or with mild systemic disease only.

Patients attending for endoscopy procedures received written information about the procedure and any preparation required prior to attending the endoscopy unit. When patients arrived for their endoscopy procedure, they met with a registered nurse who carried out an admission assessment. This included information about patients' previous medical history, medication and discharge arrangements.

Children were admitted through the local NHS trust's paediatric ward. The surgeon/dental surgeon and the anaesthetist met with the child and their parent(s)/guardian prior to starting the list. This meant risks were assessed and the parents and the child had an opportunity to ask questions about the procedure or aftercare.

Staff completed venous thromboembolism (VTE) risk assessments for patients admitted for procedures under general anaesthesia in line with national guidance. Compliance was audited and demonstrated 97.5% compliance between February 2017 and the end of January 2018. There was clear guidance for staff to follow regarding patient groups who were exempt from VTE risk assessment based on the procedures/treatment they were attending for. Other risk assessments included infection risk assessment, mobility assessment and airway assessment for patients requiring general anaesthesia.

Patients were monitored for signs of clinical deterioration. Staff monitored patients' vital observations throughout procedures carried out under general anaesthesia and conscious sedation. Staff monitored patients' vital observations at regular intervals, recording these on specific observation or anaesthetic charts. In recovery, staff continued to monitor patients closely using a modified early warning system (MEWS). This system required staff to calculate a numerical score to help them determine appropriate and prescribed actions to take if patients deteriorated. Medical assistance was available if required. Staff administered oxygen to patients receiving conscious sedation in line with national guidance.

Staff were aware of policies, procedures and pathways used to respond to deteriorating patients. There was a service level agreement with the local NHS trust to use their emergency procedures in the event of a medical emergency such as a cardiac arrest. Staff knew how to call the NHS trust emergency on call team. In a medical emergency concerning a child, the on-call consultant paediatrician was available via the emergency callout systems of the local NHS trust. The endoscopy suite had emergency equipment and pathways to follow in the event of major bleeding during endoscopy procedures. There was an escalation policy for patients identified as having sepsis during procedures and who required immediate review.

There was good compliance around surgical safety, although one audit and our observations highlighted areas not being always fully completed or focused on. The service demonstrated mostly good compliance with the World Health Organisation's (WHO) five steps to safer surgery checklist. This is an initiative designed to strengthen the processes for staff to recognise and address safety issues within operating theatres. Staff understood the WHO checklist and its importance and the practice was embedded into daily routines. The WHO checklist included assurance of positive patient identification and surgical site marking. The service audited WHO compliance by checking patient records and undertaking observations of staff completing the checklist. Audit results demonstrated improved compliance from 83% to 96% between March 2017 and January 2018 in the day surgery theatres. Compliance for endoscopy procedures had improved and demonstrated the WHO checklist was completed in more than 90% of endoscopy procedures from October 2017 to January 2018 against a target of 100%.

In a different WHO checklist audit, the service audited observation of WHO checklist performance. For example, the audit from March 2018 demonstrated performance was observed on 20 occasions and showed a lack of

compliance with eight issues. These included all staff were not introduced (2/20), lack of endoscopist engagement (1/20), sign out not verbally confirmed (4/20) and signatures or dates missing (1/20).

We observed mostly good practice when staff completed 'sign in' and 'sign out' stages of the WHO checklist. However, at times the 'sign in' and 'sign out' stages were hurried and without the full attention of all staff. Staff did not always identify equipment malfunction. We observed a procedure in operating theatre one where staff changed both the thermometer and the endoscope used. Clinicians were concerned the equipment was not working properly. However, this was not documented on the WHO checklist, although the sign out stage provided a prompt about equipment. This meant staff had to repeat questions or answers and we were concerned the checklist was not always used as effectively as it was designed to be used.

Emergency calls, such as cardiac arrest calls, went through the local NHS trust emergency call system. This ensured immediate support was available from staff with extended skills, experience and knowledge to support staff in the Day Surgery Unit.

Nursing and support staffing

There were adequate nursing staff levels to safely meet the needs of patients. The service used the Association of Perioperative Practice (AfPP) guidance to determine safe and effective staffing levels across the ward, theatre and recovery areas, and most of the time these were met. This guidance supported the review of staffing for both local and general anaesthesia sessions in theatre and safe recovery and day ward staffing. At the time of the inspection, staffing levels were appropriate in the ward, day surgery theatres and the endoscopy suite. There were 20.4 whole time equivalent (WTE) registered nurses across the whole unit with 9.9 WTE for operating department practitioners (ODPs) and healthcare assistants (HCAs). At the time of our inspection, there were four WTE registered nurse vacancies.

Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe. Bank and agency staff were used to cover staff sickness or shortages whenever possible. The service had its own pool of bank staff who had received induction and had completed day surgery, recovery or endoscopy competencies. The use of bank staff and agency staff was reducing with recruitment of staff although above target.

Endoscopy services followed and met specific guidance from the Joint Advisory Group (JAG) on workforce standards for training and the numbers of staff required per case and session. Continual review of staffing requirements was used as part of the risk assessment across the service and when a new activity was added to the service.

Staff were contracted to work their contracted hours over six days, if the service extended to a sixth day. This meant temporary staff were not used to cover additional Saturday lists when these were required to meet patients' needs/demand.

Staff were informed with key messages for the coming day. Staff from all areas attended a safety briefing each morning where issues about staffing, patient safety such as equipment issues, relevant information about training or operational messages as well as news about staff was shared.

Medical staffing

There were adequate numbers of consultants and anaesthetists to meet the needs of patients. Medical staff were employed by the local NHS trust and worked in the Day Surgery Unit under a contract. Consultants had specific theatre sessions to carry out planned day case surgery. Reviewing of practising clinical input was achieved by monthly data review from medical staffing (appraisal and investigations), which was presented and discussed at the board meeting.

Trainee doctors and anaesthetists rotated to work alongside consultants in the day surgery unit. This arrangement formed part of the medical staffing contract with the local NHS trust. The registered manager held a list of all medical staff expected to work in the day surgery unit. This list was updated regularly to reflect junior doctors' rotations.

There was a service level agreement between the local NHS trust and a local NHS Foundation Trust for the provision of dentists to carry out community dental surgery within the Day Surgery Unit.

Records

Patient care records were written and managed in a way that protected people from avoidable harm. The service used shared paper-based individual patient records with the local NHS trust. This meant staff had access to all relevant information about patients throughout their care and treatment. Patient records demonstrated a multidisciplinary and collaborative approach to patient care and were well maintained.

Records were complete, accurate, legible and up-to-date. We reviewed seven sets of patients' notes. Clinical staff completed informative evaluation notes, which reflected the needs of patients. We checked a range of information including pre-assessment, prevention of venous thromboembolism (VTE) assessment, consent, patient pathway, observations, pain management, allergies, WHO checklist, discharge checklist and summary. Information was clear and concise. Risk assessments and care plans were accurate and up-to-date.

Staff used care pathways for the patient's treatment during a day case surgery or endoscopy procedure. This was to ensure the patient received consistent evidence-based care. Pathways included pre-operative assessment, pre-operative checklist, and standard care procedures during the operation such as the five steps to safer surgery and observations. Following the procedure, staff followed the care pathway to document care provided during recovery and discharge arrangements. Care pathway included information about urgent follow up pathways with contact details of relevant referral pathways.

Staff gave patients a copy of their discharge/procedure summary so patients could share important information if further medical care was required. Staff ensured a copy of the discharge summary was sent to patients' GPs. The service had plans to audit this to ensure all discharge summaries were sent to GPs within 24 hours of patient discharge. There was a records management policy, which outlined the procedures for the creation, management, filing, storage, retrieval and destruction of health records.

Medical notes were mostly stored securely in locked trolleys and cupboards to ensure confidentiality. However, we saw some patient notes stored on a shelf in the ward area. These notes belonged to patients who had been admitted to the unit and were waiting for their procedure. On the paediatric ward, the patient notes were stored on a bed in an empty cubicle, which was at times left unattended. The cubicle was also used by staff to discuss post procedural care with the parents away from the child. This meant unauthorised people could have access confidential records about patients.

The service monitored when patients' medical records had not been not available when patients were admitted for their procedures. We reviewed a snapshot of data from 1 May 2018 and 25 May 2018, which demonstrated the patient records were not available on seven occasions, which was a relatively small number. The information recorded confirmed the notes arrived late but that the procedures lists were not held up because of this.

Medicines

Medicines were administered, stored and managed in a way that kept people safe from avoidable harm. Staff had access to the unit's medicines management policy, which was adapted from and with the permission of the local NHS trust's policy. This defined procedures to be followed for the management of medicines and included prescribing, ordering, storage, administration, recording and disposal of medicines. Staff were knowledgeable about the policy and told us how medicines were ordered, recorded and stored.

We looked at the medicines storage audits, storage security, medicines records, and supply and waste-disposal processes. Medicines, including those requiring refrigeration, were stored safely and kept within the recommended temperature range. During our inspection, we found all medicines we checked were stored securely and were only accessible to authorised staff. All drug cupboards were locked and the stocks well organised. The pharmacy department in the local NHS trust monitored fridge temperatures remotely. If temperatures were observed to be higher than recommended, the pharmacy department informed staff via email and contacted engineers to attend if required.

Staff managed medicines given intravenously (through a small vein in the arm) safely. Medicines were prescribed, drawn up for each patient and checked by registered nursing and medical staff before being administered to patients. When patients received general anaesthesia, medicines were managed by the anaesthetist. Nurse endoscopists employed by the organisation had gained an additional qualification as a non-medical prescriber. This ensured they could prescribe and administer medicines

safely to patients receiving conscious sedation. Staff asked patients about known allergies and affirmations of these were checked as part of the 'five steps to safer surgery' check procedure.

There were systems and arrangements for the safe management of controlled medicines in all areas. Two members of staff carried out daily checks of controlled medicines including stock levels and expiry dates. Staff carried out checks of controlled medicines only on the days a surgery list under general anaesthesia or an endoscopy procedure list was carried out. We checked records in one day surgery theatre and in one endoscopy room and found records confirmed daily checks when the theatre or endoscopy room was in use. Staff checked, recorded and disposed safely of controlled medicines that were wasted.

We checked five randomly chosen controlled medicines and found these were all within their expiry date and the stock level tallied with what was recorded. We checked processes for ordering of controlled medicines and found staff did not always sign the 'pink copy' in the ordering book when they took delivery of controlled medicines. Staff told us the pink form was not signed if they collected the controlled medicines themselves. We looked at pharmacy audits from June 2017, which identified an incomplete process for signing the pink copy in the controlled medicines ordering book when medicines were received from pharmacy. This meant staff did not always follow the guidance as set out in the medicines management policy.

Audits of medicines were carried out. We reviewed audit results and assurance feedback from a medication safety assurance audit carried out on 22 March 2018. Pharmacists from the local NHS trust carried out the audit. The audit identified ten areas for advised action. These included actions about the safe storage of medicines in original packaging and storage of intravenous fluids in locked storage. Another action was to write a standard operating procedure about the return of medicines to pharmacy. Managers told us some of the actions had already been achieved while others were still in progress.

There was safe prescribing of medicines in accordance with the local NHS trust policy. Medical staff prescribed medicines such as antibiotics to take home. These were supplied against outpatient prescriptions. Two nurses checked and supplied sealed labelled packets of medicines to take away (TTA packs) on discharge. Nurses attached stickers to the TTA packs, which included the patients name and date of birth and gave clear written instructions of the dose and frequency patients should take the medicines. Details of TTAs were included in the discharge summary given to patients and shared with their GP.

There were arrangements for when the dispensary system was not available. Staff used the pharmacy services at the local NHS trust. The pharmacy was open Monday to Friday from 9am to 5:30pm and on Saturday from 9am to 4pm. Out of hours (after 5pm) and at weekends, prescriptions (known as FP10s) were given to patients to take to an external pharmacy. FP10 prescriptions and log books were held securely as is legally required in locked medicine cabinets. Staff recorded when FP10's were used to ensure an audit trail and for the prevention of misuse and theft.

Staff managed oxygen therapy safely. There was access to piped oxygen in treatment areas. Where oxygen cylinders were required, these were in date and stored safely and securely.

During the period from November 2017 to March 2018, there were two medication incidents. We saw details of the incident investigation which included the underlying cause, the immediate actions taken and the actions planned to prevent reoccurrence.

Incidents

There were no never events reported during the period February 2017 to end of January 2018. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The service did not report any serious incidents between February 2017 and the end of January 2018. Serious incidents in health care, are incidents where the potential for learning is so great, or the consequences to patients, families, carers, staff or organisations are so significant, they warrant additional resources to investigate and formulate a comprehensive response. The registered manager was aware of how to record and report such incidents to the NHS's National Reporting and Learning System (NRLS) in accordance with NHS Improvement's serious incident framework (2015).

The services reported 20 clinical incidents between February 2017 and end of January 2018. Of the incidents 12

were categorised as low harm, eight were categorised as moderate harm. These included pain during the procedure, bleeding after biopsy was taken and a malfunctioning operating table causing risk to patient. There were 148 non-clinical incidents. These non-clinical incidents were those which do not involve patient care such as equipment failures.

Staff were aware of their responsibilities to raise concerns and understood the process of how to report incidents. The service used an electronic incident reporting system. All staff received training on incident reporting and were encouraged to report incidents as they occurred. Staff said they would have no hesitation in reporting incidents, and were clear about how they would report them.

There were systems to make sure incidents were investigated appropriately. An incident reporting and investigation management policy had been adapted from and with the agreement of the local hospital. Senior staff received training in incident investigation. All staff reported incidents directly onto the electronic reporting system. Once reported, incidents were reviewed by the appropriate clinical lead and where necessary investigated. Senior staff referred to the incident reporter for further information as required. Feedback was provided to the incident reporter through the electronic incident reporting system and to the wider team through daily huddles, e-mail and staff meetings. This ensured learning from incidents was shared with all relevant staff. Key risks identified were entered on the risk register and used to record the actions taken. A summary of incidents was reviewed and discussed at the monthly quality governance assurance meetings. The endoscopy user group also discussed themes and actions.

We reviewed three investigations into incidents that had happened. The incidents had been investigated and learning or actions identified to reduce the likelihood of the incident occurring again. However, there was not a standardised approach to investigation of incidents. The three incidents we reviewed were all carried out or documented differently.

Staff demonstrated an understanding of duty of candour responsibilities. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Emergency awareness and training

There was a major incident plan which outlined the decisions and actions to be taken to respond to and recover from a significant disruptive event. The staff we spoke to were aware of the major incident plan and how to access this.

There was emergency signage to help direct patients and staff to the nearest emergency exit. Doors were standard fire doors and were kept closed in line with policy. There were fire extinguishers located throughout the day surgery unit. These were all clearly marked, in date and safely mounted to prevent avoidable damage. There were regular fire alarms testing and fire evacuation arrangements and staff knew what to do and where to congregate. Staff had participated in a scenario based evacuation training event in March 2018 and said this had been very useful.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

Staff had access to policies, standard operating standards and guidelines reflecting evidence based care and treatment, which had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE), Association for Perioperative Practice (AfPP) and British Association of Day Surgery (BADS). Examples included day surgery care pathway for minor procedures under local anaesthetic, perioperative care pathway, venous thromboembolism (VTE) assessment, pre-operative checklist / surgical safety checklist and an endoscopy care pathway.

There was an array of newly written standard operating procedures (SOPs), which were divided into specialties and available as hard copies in each area. An index showed the appropriate list for each specialty for quick and easy access. We reviewed a record of SOP review data, which showed there were many SOPs being developed and there were some SOPs that had gone past their review date. For

example, the SOP for 'local guidance for topical ointment' should have been reviewed in October 2014. Managers told us they continued to work on the development of SOPs and policies specific to the Day Case UK service.

Staff working for Day Case UK linked with staff in the clinical speciality divisions within in the local NHS trust, which agreed to share the most up to date information and processes. The registered manager was copied into all governance oversight documents about care concerns and equipment updates. They received national alerts regarding equipment from the Medicines and Healthcare Products Regulatory Agency (MHRA).

The endoscopy service gained joint advisory group (JAG) accreditation in February 2018. Being able to demonstrate the use of evidence based practice formed part of the JAG accreditation. JAG sets standards about best practice and quality to ensure endoscopy units have the skills and resources required to provide high quality patient-centred care. The accreditation demonstrated the department had the competence to deliver against specifically defined, recommended standards. To maintain JAG accreditation, the service provided evidence to the accreditation body of how the service followed evidence-based practice such as implementation and compliance with scope cleaning processes.

Patients received written information in advance of attending for endoscopy procedures. The endoscopy service worked closely with the local NHS trust, which helped to ensure recent evidence based practice was followed. For example, written guidance was in line with the British Society of Gastroenterology guidelines. Staff gave patients information leaflets on discharge detailing clear post-procedure care information.

There were local safety standards for some invasive procedures (LocSSIPs), which set out the key steps necessary to deliver safe care for patients undergoing invasive procedures throughout the patient pathway. The team were planning to develop more procedures.

Nutrition and hydration

Staff offered and provided refreshments for patients following day surgery or endoscopy procedures as part of their post-procedure recovery. Patients were referred to a dietician where appropriate, however there was no formal process for this.

Pain relief

Staff monitored patients throughout procedures and offered additional pain relief if required. Nausea and pain scores were recorded within the patient's notes and documentation. We saw details of the nausea and pain audit, which showed a record of the antiemetic (anti sickness remedy) given and any pain relief provided. The record showed whether the issues were resolved or unresolved, and the action taken if unresolved. There was a 'pain and nausea audit improvement plan'. The plan had three recommendations to improve the audit and to look for trends to enhance management of pain and nausea. The action plan was still in progress at the time of our inspection. There was a plan to review and update this at the next quality assurance and performance improvement' (QAPI) committee meeting.

Auditing of patient pain was ongoing for theatre patients. Staff could recognise and report any concerns through the incident reporting system. Themes and patterns were discussed with the clinical teams and plans made to support a quality service. Audit results were used to review the current service. Recent feedback from orthopaedics had changed discharge medications for shoulder patients who had been feeling discomfort on discharge.

Patient comfort surveys were used in the endoscopy department to monitor pain. Nurses and the endoscopist were required to assess and enter perceived patient comfort scores onto an electronic patient record system. Conscious sedation was offered to patients to reduce discomfort. Pain relief medication was given intravenously where needed. Monthly reports were reviewed through endoscopy governance procedures and the board.

Patient outcomes

The service had limited participation in national patient outcome audits through their close working relationship with the local NHS trust. Unplanned overnight stays were reported as incidents and reviewed. Patients were admitted to the local NHS trust if complications arose during day surgery. The service audited how many day case episodes were converted into inpatient admissions. Between August 2017 and end of January 2018, 31 patients were converted to inpatient admissions. The majority of these (20) were planned admissions with a bed booked in the local NHS trust following surgery. For the remaining 11

patients, the reasons for admission were patient risks associated with previous medical history or further observation was required. In five cases, patients were admitted because of complications during surgery.

There was an effective system to audit and monitor the efficiency/utilisation of the procedure lists. The intraoperative care plan was recorded using an electronic patient management system. For example, staff entered the time the procedure started and ended, any complications or equipment malfunction. Information about who was present during the procedure and their roles was also recorded. However, the service used three different electronic recording systems to capture data, which staff described as labour intensive. This system was necessary to ensure relevant data was captured to allow for benchmarking of the effectiveness of the services delivered. The service was working towards benchmarking with other and similar services.

The endoscopy service had recently started to participate in a national benchmarking project. Endoscopy activity data was uploaded to a national endoscopy database project. This data did not include any patient identifiable information but would allow for national benchmarking of the service and for each individual endoscopist. Data was not yet available to review the performance of the service and of individuals carrying out endoscopy procedures.

The endoscopy service had participated in a national polyp identification audit, which had now been completed. The service carried out endoscopy screening procedures for the local NHS trust and offered the same service to another nearby NHS trust. As a result, the service participated in the national and regional bowel cancer screening programme (BCSP) database, which was discussed and audited at regular intervals. Attendees at these meeting included the regional cancer screening service, Public Health England. The endoscopy service had plans to participate in the National Endoscopy database, which bench marked endoscopy units and individual endoscopists' practice.

Endoscopy services were JAG accredited and this included national audit and comparisons of key indicators such as patient comfort scores. These were also part of the quality report and board reports. We reviewed comfort score data from August 2017 to end of January 2018 and found most patients experienced none or less than two episodes of discomfort during the endoscopy procedure. Audit results demonstrated between 7% to 9% of patients reported significant discomfort and 2%-3% of patients experienced frequent and extreme discomfort against a maximum tolerance of 10% of all patient experiences. However, the audit also demonstrated the comfort score was not completed in between 11-22% of all endoscopy procedures carried out in the same period.

There was a programme of internal audits carried out monitor performance and to maintain standards. The audits included audits for infection control and compliance with safer surgery checklist. There were action plans following participation in audits to address areas requiring improvement. Regular reviews were undertaken to monitor progress.

Competent staff

Staff mostly had the skills, knowledge and experience to deliver effective care and treatment to patients although staff did not receive specific training in supporting patients living with dementia. There was an induction programme for new staff, current staff changing job /work area and bank/agency staff new to the area to ensure the skills required were assessed and taught. This included an introduction to the team and orientation to the department, on-call and 'bleep' arrangements, resuscitation procedures and fire safety procedures and assembly points.

Staff were encouraged to develop their knowledge and skills to improve the quality of care provided. There was a comprehensive competence framework designed to ensure staff received required training and were competent to carry out their job. Staff received specialty specific training and updates to ensure the most recent information was shared. Records were available on training information boards alongside details of upcoming training. This included acute skills days, pressure ulcer prevention study, paediatric immediate life support and mentorship updates. Updates, learning and staff development was confirmed through appraisals. Staff said they were encouraged to be responsible for their own competency. Data confirmed all staff had received their appraisal within the last 12 months at the time of our inspection.

Some staff attended external groups where information was shared. For example, some staff attended southwest

meetings in endoscopy and ophthalmology. Some staff had also attended national or regional conferences to stay well-informed of current practices in day case and endoscopy services.

There was a supervision policy, which provided a clear understanding of supervisory processes that focused on the personal and professional development of staff (excluding medical and dental staff). It also provided a framework for reporting of supervisory activity which could then be reported for governance purposes.

All registered nurses held an immediate life support qualification. This was reviewed and updated every year by attending face-to-face training and assessment at the local NHS trust.

Staff were encouraged and supported to undertake further post registration courses to enhance their knowledge and skills. For example, ten registered nurses held a mentorship course allowing them to mentor student nurses on placement. There was one nurse endoscopist and another nurse currently in training to become a nurse endoscopist. One senior nurse held a post registration course in care of the child in a specialised adult unit and there were plans to support other nurses to achieve this in the future.

There were arrangements for student nurses to work in the day surgery unit. There were sufficient number of registered nurses who were student nurse mentors and as such received regular updates about student nurse mentoring.

Multidisciplinary working

We saw evidence that staff worked professionally and cooperatively across different disciplines. This was to ensure care was coordinated to meet the needs of patients. We saw evidence of external multidisciplinary discussions/ referrals working well. There were service level agreements with the local NHS trust for a range of services including pharmacy, imaging, pathology, housekeeping, IT, portering and sterile services. Medical staff met with patients in outpatient departments and referred patients to the Day Surgery Unit for their day surgery procedures. GPs referred patients directly for endoscopy procedures or to clinicians within the local NHS trust for diagnostic endoscopy procedures. The clinician then referred patients to the Day Surgery Unit endoscopy service. Patients were discussed in multidisciplinary meetings within the NHS trust and relevant information was shared with staff in the Day Surgery Unit.

There were arrangements to ensure patients attending for procedures in the Day Surgery Unit, could be admitted to the local NHS trust if necessary. This happened rarely and only if they were not fit to be discharged after their procedure or if complications arose. This meant patients could be admitted directly from the Day Surgery Unit without having to go through the emergency department.

Staff arranged post-operative or endoscopy follow up appointments at the local NHS trust if required, when the patient was discharged. Staff could also refer patients onwards to specialist nurses or physiotherapy.

There were effective processes to ensure safe discharge of patients following day case procedures. Staff collected information from patients about arrangements they had made to be collected following the procedure. Staff insisted friends or family, who were supporting and caring for patients following their procedure, collected patients from the day surgery unit. This was to ensure all relevant information was shared about actions in case of unplanned complications following the procedure.

Information about patients was shared with GPs on discharge from the service. Nurses completed the discharge summary and a final assessment summary was completed by the surgeon or endoscopist on the electronic record system. A discharge letter was then created and given to the patient, and sent to the patient's GP. Written instructions were provided for patients and their carers about post procedure care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

There were processes for obtaining consent. Patients received written information through email or by post ahead of attending for day surgery procedures. This meant patients were informed about the procedure and risks associated with the procedure. Medical staff met with patients in the pre-assessment unit to discuss and obtain written consent.

Staff obtained written consent from patients attending for endoscopy procedures on the day of the procedure. When patients arrived for their procedure nursing staff admitted

them before the endoscopist met with the patient to obtain consent. Patients received written information before ahead of attending for their endoscopy procedure. The bookings team contacted all patients prior to their appointment to discuss the procedure, any preparation requirements, post procedure care and offered an opportunity for patients to ask questions. This meant they were informed of the procedure they attended for before arriving. However, we did not see this was documented in detail in patient's notes.

Written consent was by the completion and signing of pre-printed consent forms. The patient and the clinician signed and dated the consent forms, which held information about the procedure and associated risks, at the point of discussion. However, we did not see additional contemporaneous documentation about decision making records that contained key points of the consent discussion and the patient's decision, in accordance with national guidance (Consent: Supported Decision-Making: A guide to good practice. Royal College of Surgeons, 2016).

There was a policy for consent for examination or treatment, which set out the standards and procedures to ensure health professionals could comply with the guidance. The policy described the process for obtaining consent and managing the risks associated with consent. The policy stated patients receiving elective treatment or investigation should be familiar with the contents of their consent form before they arrive for the actual procedure. Patients were advised to access information on the Day Case UK webpage on the local NHS trust's website. Information about procedures carried out was presented including risks of day case procedures. The service audited consent processes and issues identified were discussed at the 'quality assurance and performance improvement' committee meeting and shared with staff through daily huddles.

We observed good practice for obtaining consent during surgery concerning children. For example, we observed a community children's' dental surgery list. Before the day of the procedure, the community dentist obtained consent from parents and informed them about what they anticipated the surgical procedure would entail. Consent was re-affirmed on the day of surgery. Once the child was under general anaesthesia, dental surgeons carried out a thorough examination using X-ray if required. If further teeth extractions were required, the surgeon stopped and spoke with parents, adding this to the consent form. Dental surgeons met with the child and their parents when they attended on the day of the appointment and re-affirmed consent at this point. The consent form used provided an opportunity for the children or young people to sign the consent form as well as their parents.

There was a resuscitation policy, which aimed to ensure comprehensive management of decisions regarding resuscitation status. These decisions were communicated to all staff at a 'staff briefing'. Staff came together in the morning to discuss the list of procedures planned for the operating theatre or the procedure room they were working in that morning. This was in line with the WHO safer surgery guidance.

There was access to a Deprivation of Liberty Safeguards (DoLS) authorisation policy, which aimed to set out the requirements of all staff in respect of the Mental Capacity Act 2005 and the accompanying Code of Practice. The policy set out the framework of responsibilities for the assessment of mental capacity and the tasks associated with working with people who did not have mental capacity. Staff we spoke with were aware of but had not received regular training and updates in DoLS and mental capacity training. However, there had never been an occurrence where they needed to apply for a DoLS authorisation, and we recognised this would be unusual.

Staff were aware of mental capacity assessments and described an example when they had postponed a procedure because staff were not assured the patient had mental capacity to consent to the proposed procedure.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

Staff showed an encouraging, sensitive and supportive attitude to patients and their relatives. Staff were passionate about providing a caring service. We observed staff interact with patients in a kind manner and with compassion. Staff were polite and professional in their interactions and yet made it personal to the individual.

Good

Surgery

Staff took time to interact with patients in a respectful and considerate manner. Staff at all levels demonstrated compassion in every element of the care and service they provided. We observed interactions between staff and patients, and their relatives, and found staff were skilled in talking in an open and approachable way but always remained professional.

Staff took care to maintain patients' privacy and dignity. We saw staff draw curtains around cubicles and gain the permission of the patient before entering. During procedures we observed all staff taking care to maintain patients' dignity. A 'privacy and dignity and single sex accommodation' policy provided guidance and procedures on respecting privacy and dignity at all times and for ensuring patients and carers were treated with courtesy and respect.

The service sought the views of patients by asking for feedback. Patients were asked to completed feedback questionnaires such as the NHS Friends and Family Test (FFT) or feedback questionnaires from the local trust known as 'I Want Great Care' (IWGC). During the period from August 2017 to January 2018, the FFT response rates (the number of people who completed the survey) ranged from 14% to 27%. Feedback results showed 95% to 100% were likely or very likely to recommend the service to friends and family if they needed similar treatment or care. In the same period, the service reported an average patient satisfactory score of 4.9 (out of 5) for day surgery services and 4.93 (out of 5) for endoscopy services. There was an average of 160 responses across all three services (day surgery, endoscopy and services delivered at the Castleton Day Unit).

We sought the views of patients before and during the inspection by leaving comment cards and boxes to leave feedback. We received 30 completed feedback cards containing the views of patients about the care they had received. All but one of the feedback responses were positive, with comments such as "my experience was excellent"," I cannot fault the service", and "staff were professional, friendly, caring and staff answered all my questions."

Understanding and involvement of patients and those close to them

Patients were involved in every stage of their care and treatment. Patients said procedures had been explained and they felt included in the treatment plan and were well informed. This included the consultant explaining the surgery events in detail and nurses talking patients through information leaflets. Staff recognised and supported patient anxieties. For example, one patient felt upset and found the nurse understood their concern and provided reassuring advice.

Relatives we spoke with also said they felt involved in the treatment decision-making process. One relative said, "Everyone was really friendly and explained things very clearly and listened to you."

Emotional support

We observed staff communicate with patients in a range of different situations. We observed staff giving patients important information about their care in a manner they understood. Staff took time to answer and explain when patients asked questions. We observed appropriate use of humour at times when staff interacted with patients. There were arrangements to ensure privacy and support for patients receiving diagnostic results if required.

There was restricted access to relatives to the unit due to both capacity and patient privacy and dignity. However, individual patients' needs were taken into consideration should a patient need physical or psychological support from their relatives.

Are surgery services responsive?

Good

We rated responsive as good.

Service delivery to meet the needs of local people

Services were planned and delivered in a way that met the needs of the local population. The service worked with the local NHS trust and other stakeholders including GPs, to meet the needs of the local population. Services were provided Monday to Friday from 8am to 8pm. Patients were booked onto sessions through the local NHS trust contract. Ophthalmology and endoscopy booking was led by the day surgery unit. The service managed bookings on all other specialties through scheduling meetings and this supported patient individual needs, for example individual planning for adult community dental patients and patients with limited mobility. Private patients accessed the service through GP referrals.

Good

Surgery

The service provided both day case and endoscopy services under contract with the local NHS trust. Patients were assessed through the NHS trust's pre-assessment processes to ensure they were suitable for day case surgery. The two organisations met weekly to ensure the schedules for day surgery were coordinated.

The community dental service provided all pre-assessment for planned paediatric dental cases. For all children and young people admitted for day case procedures, initial assessment took place at the local NHS trust by a registered children's nurse. Needs assessments included physical, emotional and mental wellbeing, reasonable adjustments or age-specific requirements. The registered children's nurse worked with children and families to support those with learning disabilities or complex needs, including pre-visits to support their care and treatment.

Meeting people's individual needs

The unit was easy to find, as it was signposted and situated close to the main entrance of the local NHS trust. There was parking opposite the main hospital building and there was a drop off point available close to the main entrance.

Services were planned, coordinated and delivered to consider patients with complex needs to optimise care, treatment and access to services. The needs of patients were highlighted to staff following pre-surgery assessment appointment. There were records in patients' notes to advise staff to specific physical or psychological support required. Staff told us of examples in community dental treatment provision, for example, where patients required extra support. In one case, a patient with learning difficulties attended for procedure. Meetings were held in advance of the appointment with the patient's GP, anaesthetist, radiographer and carer to discuss an action plan. Arrangements were made for the patient to attend on a quiet day with additional support provided. There was also liaison with the learning disability specialist nurse at the local NHS trust to provide additional support.

The endoscopy booking teams contacted patients to discuss their endoscopy treatment. Patients who required additional support for their endoscopy preparation, such as differing levels of sedation, were highlighted to clinical staff. Telephone guidance was given, or preparation could be completed on site if specific support was required. The service had a designated admission cubicle for this purpose, with an en suite toilet facility.

Reception staff greeted patients and booked them onto the electronic patient system. Patients were directed to the adjoining waiting area until they were called through by the nurse. There were four consulting rooms where nurses took patients to complete paperwork required for their procedure and to meet the surgeon. There were two operating theatres and two endoscopy rooms. Following surgery or endoscopy procedures, patients were moved to the first stage recovery area and then moved to the ward area or the endoscopy lounge to wait for their discharge paperwork and medication. Patients would change in gender specific changing areas and place their belongings in a basket, which stayed with them for the duration of their appointment.

Processes to identify patients' communication needs were limited. Staff carried out a basic assessment of patients' communication needs as part of the admission process. Translation services were available for patients, and the reception staff could book these in advance of treatment if required. There was an electronic patient record system where different alerts had been added. These included the need for an interpreter and if patients had a learning difficulty. However, other communication needs such as hard of hearing and poor vision, were not highlighted as an alert. This meant the service was not fully compliant with the Accessible Information Standards. These standards became obligatory in 2016 for all NHS care providers.

There was a dementia strategy with a plan for the local NHS trust and subsidiary organisations, to deliver high quality person-centred care for people living with dementia and their carers. The strategy included key objectives for staff training, care delivery, carers support programme and partnership working. The strategy was not specific to Day Case UK LLP but we found that reasonable adjustments had been made to enhance a dementia friendly environment. A dementia advisor had visited the unit and made suggestions about how the unit could be more dementia friendly including signage, appropriate wall colouring and flooring and easy read clocks.

All children were admitted through the children and young people's unit within the local NHS trust. They and their parents or guardian were accompanied to the day surgery unit by a children's nurse for their anaesthetic and surgery procedures. While in the day case unit, children were brought directly to anaesthetic rooms as close to anaesthetic time as possible to reduce any anxiety.

Children were admitted to a dedicated child-friendly area in the recovery unit, and following their first stage recovery period, were accompanied back to the children's ward. Parents could accompany the child into the anaesthetic room and the recovery area after the surgical procedure.

Mobility equipment was available across both sites to support those patients who required mobility support such as wheelchairs and hoists to assist them to their surgery with privacy and dignity. This requirement would normally be known in advance through booking teams and scheduling. Portable hearing loops had been installed for people with hearing loss.

There was a standard operating procedure (SOP) providing guidance on chaperone services available to both staff and patients. Patients could request a chaperone to support them, and staff knew in what circumstances to make sure these were offered to patients.

Access and flow

Patients were given appointments but could change these if they were not able to attend. Services were provided Monday to Friday from 8am to 8pm with additional Saturday lists when required to reduce waiting lists. If patients required further follow-up appointments, staff ensured these were made before the patients were discharged.

The organisation worked closely with the local NHS trust to deliver patient care within its agreed contract. This included a responsibility to treat patients in line with referral to treatment time standards. There was a weekly scheduling meeting between the two organisations to review the previous week's performance, discuss additional sessions to meet demand, and review waiting lists. The weekly scheduling meetings provided an opportunity for feedback between the local NHS trust and Day Case UK (DCUK) about previous sessions and look for any improvements that could be made.

Staff used technology to monitor theatre times to make sure patients were treated on time. An electronic system was used to capture data about how well the services were operating. Data was recorded about theatre utilisation and turnaround times, and was used to audit theatre delays. We reviewed the DCUK Highlights Report from March 2018, which identified the scheduled procedures that had not been achieved in any month from August 2017 to end of January 2018.

During periods of winter pressures at the local NHS trust, there was an agreement to use the ward area to accommodate the hospital's patients overnight. There was a standard operating procedure to guide staff when the unit was used as an escalation area for inpatients from the local NHS trust. The care and treatment of these patients were the responsibility of local NHS trust who provided additional nurses to look after the patients. Yeovil District Hospital staff. The ward area was used on 15 days as an escalation area and had resulted in the cancellation of one procedure. Staff had worked hard to ensure day case procedures were not cancelled when patients were accommodated in their ward overnight. We were told the local NHS trust's winter pressure plan for 2018/19 did not include Day Surgery Unit as an area to accommodate patients at time of increased operational pressures.

There were minimal cancellations or readmissions which were below the organisation's target. Some patients were transferred to the local NHS trust after their procedures, but most of these were planned. Monthly quality reports showed the number of cancellations by the service, the number of patients admitted to the local NHS trust post procedure and the number of readmissions. There were nine cancelled procedures for a non-clinical reason in the 12 months prior to the inspection with 89% of patients offered another appointment within 28 days of the cancelled appointment. Data demonstrated there were between two and eight cancellations per month between August 2017 and end of January 2018 (against a local maximum target of 20 cancellations) for day surgery procedures. There were no cancellations of any endoscopy procedures. For the same period, data showed 31 patients were admitted to the local NHS trust following surgery or investigation procedures against a local target of zero. However, this number included patients who had a planned overnight inpatient bed booked. There were three cases of unplanned readmissions within 28 days of discharge in the reporting period from February 2017 to end of January 2018 against a target of zero.

At times, there were delays to the start times of procedure lists. The service audited delayed starts to procedure lists in the operating theatres and the endoscopy service. Data showed no improvement from March 2017 (34% delayed procedures) to March 2018 (51%). The most common cause

was delays due to processes to obtain consent. This had led to discussion and plans for nurses to be trained to obtain consent for some low risk procedures. This project was still in progress at the time of our inspection.

The service had effective processes to plan for optimised use of its operating theatres, although did not always achieve full utilisation. Data demonstrated the average scheduled use of operating theatres was 96.9% and 98.9% for the endoscopy suite between March 2017 and end of January 2018. However, data demonstrated there were an average of 15.7% 'stood down' sessions between April 2017 and January 2018 making the actual utilisation 84.3% against a plan of 100% of what had been scheduled. Utilisation and productivity was reviewed monthly and discussed at the board meeting.

Not all patients were being seen on time. Compliance with scheduled procedure starting times had deteriorated, although there were good turnaround times between patients. An audit of turnaround time efficiency and delayed starts in endoscopy had been carried out in November 2017. The aim was to evaluate the turnaround time between endoscopy cases and the patient flow through the department to ensure cases started on time. A total of 200 patients were reviewed with results showing an average turnaround time of 6.47 minutes which exceeded (was better than) the internal target and professional standard of up to 10 minutes. Of the 200 cases reviewed, there were 69 delayed starts (34.5%) equating to a total of 585 minutes lost. The reasons for the delay included endoscopists obtaining consent, awaiting scope, and staff training. A comparison of delayed starts was conducted in March 2018. A total of 129 cases were reviewed with 67 delayed starts (51.9%). Results showed a worsening trend relating to consent. Managers and key clinical staff were developing an action plan to reduce delayed stated. This included the development of nurses obtaining consent and training was being developed to train nurses accordingly.

We reviewed an audit of patients who did not attend for their scheduled endoscopy procedures. Between December 2017 and May 2018, 73 patients did not attend for their planned procedures. This was an average of 2.8% of all procedures. Staff notified the booking team, who contacted the patient to re-book their appointment. If the patient was receiving an endoscopy in relation to a high-risk cancer diagnosis, the service informed their GP if they did not attend. When children were not brought in for their scheduled procedures, staff phoned the parents to remind them of the appointment and re-arranged the operating theatre list to accommodate late arrivals. If a child was not brought to a scheduled dental appointment, staff informed the community dental team so they could follow this up.

Patients' were booked to arrive at the unit at the same time for the morning and again for the afternoon procedure lists. This was because the surgeon saw all patients prior to starting the operating theatre list in either the morning or afternoon to obtain their consent and answer any questions or address any concerns. Staff kept patients updated on waiting times during the day, and there were posters in the waiting areas providing information about the appointment time/schedule.

Learning from complaints and concerns

The service had policies and processes to appropriately investigate, monitor and evaluate complaints. There was a 'complaints and concerns policy', which was accessible to staff electronically and a printed copy was kept in the department. Patients could access this via the Day Case UK webpage on the local NHS trust's website.

Leaflets and posters were available around the unit informing patients about how to make a complaint or raise a concern. Patients we spoke with were aware of how to raise a concern or make a formal complaint. However, none of the patients we spoke with during the inspection had any complaints about the service. All comments we heard were positive. There had been just one formal complaint during the period from February 2017 to January 2018.

The processes and information provided for patients to make complaints included the use of the Patient Advice and Liaison Service through a contractual agreement with the local NHS trust. Each patient was provided with the opportunity to complete an 'I Want Great Care' feedback form, which, if it was not done anonymously, could be followed up for any concerns raised. To help resolve complaints before they became formal, a letter was sent to the complainant offering a meeting with the registered manager to resolve the issue.

The individuals responsible for overseeing the management of complaints were the registered manager, the theatre lead and the endoscopy lead. Complaints and concerns reported to the local NHS trust's Patient Advice

and Liaison Service team would be logged electronically on a shared system and investigated by the responsible individual. These were subsequently reported through the respective governance committees.

Patient concerns and complaints were used to improve the quality of patient care and the service provided. For example, staff told us they had purchased dignity shorts (disposable shorts that ensure patients dignity was maintained during procedures) in larger sizes because of feedback from patients.

Learning from complaints was shared with staff through the daily huddles, nurse leads meetings and through the quality and board meetings as required. Learning from concerns and complaints was also included in NHS trust's forums to ensure improvements were shared between services.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership

The leadership team of the service had the skills, knowledge and integrity to lead the service. There was a registered manager (RM) who oversaw the day to day running of the service. The RM was supported by the clinical lead who was also the medical director from the local NHS trust. There was a representative from Ambulatory Surgery International who provided clinical and leadership support as required. The registered manager held a range of post registration professional qualifications, including leadership programmes. Day Case UK LLP (DCUK) was a new organisation formed in March 2017. The leadership team had formed the DCUK team through mutual respect and valuing the team members. Managers maintained a high profile in the unit, and it was a priority to share information with DCUK staff and for them to have the opportunity to share ideas to plan and improve their service.

The leadership team were an experienced team with a commitment to patients who used the service, to their staff and each other. DCUK leaders were visible and operated an 'open door' policy. Staff told us they felt supported by leaders of the service. We received consistently positive feedback from staff who had a high regard and respect for their managers.

The service worked closely with the local NHS trust. The senior leadership teams interacted daily. This was to ensure any changes to scheduling were made or urgent and emergency procedures could be treated. The registered manager had a dual role as they also held a senior leadership position within the local NHS trust. Although the dual role was demanding, the registered manager felt it was an advantage to ensure a close working relationship and this ensuring a safe and efficient environment to meet the needs of patients.

Vision and strategy

There was a corporate vision and strategy, which was to 'develop a top-class day surgery model'. The strategy outlined nine priorities in how to achieve this. These strategies included highly specialised facilities, efficient processes and productivity and highly trained staff. The strategy also included performance benchmarking and performance measures including quality measures, creating a supportive environment for staff and involving staff in service development.

The vision included plans of building a new unit to include both Day Case UK (DCUK) sites adjacent to the local NHS trust. DCUK and the local NHS trust had secured planning permission and financial arrangements for the new build. The decision for the new-build was with the local clinical commissioning group (CCG). The CCG had launched a countywide review of the delivery of healthcare services due to be concluded in 2020 and the new unit was being considered within these plans.

Staff were aware of the vision and strategy. Staff told us that plans for the new build had been shared with them and they had been able to comment and contribute with ideas. Staff felt involved with the project and looked forward to moving to new facilities.

Quality priorities had been agreed with the local NHS trust for 2018/19. There were four themes: safer care, patient experience, 'right care, right time and right place' and staff retention and wellbeing. Information about the quality priorities was displayed in staff areas across both sites.

Culture

Good

Surgery

There was a culture of openness, candour and honesty amongst staff. However, the process of the transfer of staff and services to Day Case UK LLP had provided some challenges for morale and team working. Staff told us some of their colleagues had left because they felt unsure about leaving NHS employment, and the new operational structure. However, all staff we spoke with told us there was good team working, good leadership and a supportive culture of improving care and treatment delivered to patients. All staff we met said they felt valued and part of the team.

Staff felt they could suggest and be involved with service improvement initiatives. Staff felt the processes for bringing change were efficient although still subjected to the highest scrutiny. Frontline staff and senior managers were passionate about providing a high-quality service for patients with a continual drive to improve the delivery of care.

Good practice was recognised. The service collected compliments and good feedback from patients. If individual staff members were mentioned in these, this was highlighted and celebrated during the morning safety huddle. A member of staff had been nominated for an award from the local NHS trust in recognition of the care they delivered. Managers and staff were extremely proud of the organisation and the contribution they made to the healthcare of local people. They told us patient care was at the centre of everything they did.

There were daily staff huddles where senior leaders shared important information. There were also regular staff meetings, which were held on a scheduled morning each month with no planned surgical lists. This session was used to bring staff together for meetings, training or auditing purposes. All staff worked together to assess and plan ongoing care and treatment in a timely way. All staff felt part of the team and were complimentary about each other and valued each other's input to the team. All staff worked together to assess and plan ongoing care and treatment in a timely way. All staff felt part of the team and were complimentary about each other and valued each other's input to the team.

The service had processes to ensure compliance with National Safety Standards for Invasive Procedures (NatSSIPs) to prevent the occurrence of the so-called never events. For example, there were checklists for the five steps to safe surgery (WHO checklists) and processes to ensure compliance. There were posters displayed in staff offices explaining how to ensure compliance with NatSSIPs. This poster stated that NatSSIPs were not just about WHO safer surgery checklist but also about a safety culture, which considers teamwork and human factors. Staff we asked stated they felt confident to speak up during safety briefings before procedures lists started or at the 'sign in' stage, if they had any concerns. Designated staff attended 'NatSSIPs meetings' in the local NHS trust, to share information and to ensure compliance. Minutes of meetings confirmed different areas of compliance were discussed, as well as compliance with individual procedures. Some staff had received 'human factors' training provided by the local NHS trust. Human factors training is about understanding human behaviour and performance and how this can contribute to the prevention of errors connected to human factors. There were planned sessions for additional staff to attend throughout the year.

Staff felt able to raise concerns internally and knew how to do so. We spoke with the Freedom to Speak-up Guardian (an independent voice among their peers to support people to raise concerns with the leadership team). They were new to the role but felt supported by senior leaders and from the Guardians at the local NHS trust. They had also been invited to attend additional training to enhance their confidence in the role. There was no specific Day Case UK Freedom to Speak-up policy, but there was a policy from the local NHS trust available to staff through the contractual service level agreement.

Staff human resource (HR)/personnel issues were managed through a service level agreement with the local NHS trust. Staff had access to HR policies on the intranet and there were hard copies available. The service did not have their own HR policies as they were all managed within the structures and frameworks of the local NHS trust. Managers operated an open listening culture to support staff through HR processes, learning from events and ensuring the individual could share and be involved in finding solutions.

The service collected data on Workforce Race Equality Standards in line with legislation. Data was shared with the local NHS trust, which was responsible for reporting the data.

Governance

There were effective governance structures to monitor performance and risks to provide safe, good quality care.

Good

Surgery

The Day Case UK (DCUK) governance structure involved a quality committee and a board. The board consisted of two executive directors from the local NHS trust and two executive directors from Ambulatory Surgery International. There was no representation from any non-executive directors on the board. There were monthly meetings where key performance indicators were discussed and any concerns raised. Both successes and concerns were fed back to the DCUK teams for discussion, and solutions to improve or celebrate success.

Governance and risk management processes were fit for purpose and demonstrated a positive working relationship between all staff teams and the management team. The governance framework was focused on supporting the delivery of safe, quality care. There were clear reporting structures from the front-line staff up to the management team and vice-versa. A variety of meetings fed into the quality governance assurance process, which ensured a comprehensive clinical and operational oversight.

Day Case UK (DCUK), through the local NHS trust contractual agreements, linked with the local NHS trust governance structures. All incident reporting and governance reporting to external bodies was carried out by the local NHS trust. Performance measures were monitored by the DCUK quality committee and presented to the board.

The endoscopy and surgery scheduling meeting (led by DCUK lead staff) ensured effective use of DCUK services. The service submitted 'Day Case UK Highlight Reports' to the local NHS trust board every other month, which were presented to the board by the DCUK nominated individual.

Day Case UK (DCUK) held a contract with the local NHS trust for the provision of children's day surgery services. Delivery of this contract was monitored monthly and any concerns raised in relation to the quality of care of paediatric patients were discussed. Overall monitoring of the quality of local NHS trust's children's services remained within the local NHS trust's governance structures.

A monthly operating board had an overall oversight and assurance of performance and delivery of safe and effective services. We saw the minutes of the board meeting where items discussed included action items, service optimisation progress and upcoming focus, performance review, productivity report and quality report.

There was a monthly 'quality assurance and performance improvement' (QAPI) committee meeting to measure, monitor, evaluate and improve all aspects of quality and performance of services delivered by Day Case UK (DCUK). The operating clinicians and their employing organisation held clinical accountability. The director for Day Case UK provided clinical leadership for the service and chaired the QAPI Committee. The director for the DCUK was also the medical director for the local NHS trust. This meant services, governance and strategy was closely aligned to ensure the safe delivery of care and treatment. We reviewed minutes of meeting from January 2018, which confirmed that issues, such as follow up from previous meetings, new items, quality and performance were discussed. This was supported by a QAPI dashboard, which was reviewed as part of the agenda. The QAPI dashboard held information about quality (such as data about infection) and performance data (including data about patients admitted to hospital post-surgery or investigation procedure.

The endoscopy lead attended monthly endoscopy user group meetings to identify issues and opportunities relating to performance and quality delivery. These meetings were held in the local NHS trust. Relevant clinicians who used the endoscopy service in the care and treatment of their patients, attended the meetings. We reviewed minutes of meetings, which included information about incidents, 30-day mortality and re-admission to hospital within eight days. Identified 30-day mortality reviews were carried out as part of the local NHS trust's mortality review processes. Endoscopists were involved and outcomes/opportunities for learning were shared with staff from the endoscopy unit.

The endoscopy service was required to monitor and submit data every year to the Joint Advisory Group (JAG) for gastro-intestinal endoscopy. This included data about patients' re-admission within eight days, use of medicines to reverse conscious sedation medicines and 30-day mortality audits. The results were discussed at the endoscopy users group where any actions were decided. The team were moving from six-monthly to monthly audits to improve timeliness of action responses. Any issues identified would be audited and any identified risks added to the risk register if required.

Regular internal audits were carried out to monitor performance and to maintain standards. There were action

plans following participation in audits to address areas requiring improvement. Regular reviews were undertaken to monitor progress. Staff were included in specialty review meetings where patient outcomes and updates to care requirements were discussed and how these affected the services provide by Day Case UK. Any patient outcome concerns would either be reported directly to the provider through the clinical teams from the local NHS trust or from a direct patient telephone call.

There were daily staff huddles where senior leaders shared important information. Staff from all areas (ward, theatre, recovery and endoscopy) met to discuss any issues relating to the listed procedures (staffing or equipment), patient needs and to share any relevant news or information. The service had recently (March 2018) started to record issues discussed in daily huddles. There were also regular staff meetings, which were held on a scheduled morning each month with no planned surgical or endoscopy lists. This session was used to bring staff together for meetings, training or auditing purposes.

Managing risks, issues and performance

There were systems and arrangements to identify, record and manage risks. There was a 'risk management strategy', which outlined a framework to promote a culture whereby patient safety and quality was at the heart of all clinical practice. The service understood, recognised and reported their risks.

Risks entered on the risk register included the date they were entered, existing controls, actions required and taken and a review date. There was a comprehensive risk register with risks rated according to the risk posed (severity) and the likelihood of them occurring in accordance with national guidance. The registered manager reviewed the risk register each week and recorded updates from each risk owner to ensured risks were reviewed regularly. Each risk had a lead manager who was responsible for progress and management of the risk. Once risks were reduced or resolved, these were archived with an audit trail to demonstrate how the risk was managed.

The risk register was available for all staff to review and was used to manage risks through regular updates on actions and risk ratings. The registered manager shared risks with DCUK leads and teams to involve all staff in finding solutions. We discussed risks with the senior leaders and these risks were aligned to those registered on the risk register. Registered risks included use of the ward area at times of winter pressures, availability of equipment to cope with increasing demand and multiple use of three computer systems.

Complaints were presented to the monthly QAPI meeting with learning and actions identified accordingly. In addition, the 'patient experience and engagement committee' from the local NHS trust reviewed all complaints activity. A member of the Day Case UK's senior team sat on this committee. A formal complaints report identified themes and trends across services and highlighted key actions required to drive improvement. The patient experience and engagement committee reported to the local NHS trust's 'governance and quality assurance committee'.

Managing information

Information was shared effectively with staff through a variety of ways. There was a daily huddle attended by all staff on duty. Each operating theatre and endoscopy room had a safety briefing before the procedures lists started. This meant important information about patients was shared to ensure safety. There were notice boards and a group email to assist the sharing of relevant information.

Information to deliver effective care was readily available. There were a range of documentation templates, such as care pathways, and these was easily accessible. There were three IT systems used, which did not interface, and some staff were frustrated about the repetitive nature of data entry. Although repetitive, staff and managers were confident that data was entered in a timely way and accurately.

Patient discharge information included a carbonated form with the top yellow copy being given to patients. Information included wound care, appointments, medication, and telephone contact details. Patients were told how to contact the services in the event of a medical complication following surgical or endoscopy procedures.

Information was sent out to patients with links to the local NHS trust's website for information about surgical procedures. This was sent by email, unless a patient did not have access to emails, when they received a printed copy of the information.

Engagement

Good

Surgery

There were systems to engage with patients and the public to ensure regular feedback on services. This was used for learning and development. Patient experience was a key performance measure in the Day Case UK (DCUK) vision. Patient feedback was gathered from a range of different platforms such as 'thank you' cards, 'I Want Great Care' feedback and the NHS Friends and Family Test. In addition, feedback was also received through the website for the local NHS trust and social media. Feedback from NHS Choices was shared with team leaders for cascading to teams on both sites. Feedback about the patient experience was discussed through the quality and board structures of DCUK and daily staff huddles. Staff groups also received regular information by e-mail.

Staff feedback was collected and shared in daily huddles to improve the service. Staff had taken part in a staff survey and the results from this was still being collated. We saw monthly staff newsletters which included details of new starters, training, recruitment, procedural updates, departmental news, social events and recognition of continued hard work by the teams. This was emailed to staff and hard copies were available on the unit. There was a monthly governance meeting planned to support staff training in areas identified from patient feedback. Staff were actively involved in finding solutions to patient feedback.

Patient feedback comments were summarised and displayed on the staff notice board. Comments included, "All of the staff were friendly, caring and knowledgeable", "nothing can be improved, they were fab!" and "everyone made me feel very special and important as though I was their only patient and unique."

Managers of the endoscopy service attended regular meetings (Bowel Cancer Screening Programme Board) with similar services across Somerset. We reviewed minutes of a meeting in May 2017, which included evidence of discussion of performance (uptake) 'roll out' plans and bowel screening related incidents. This meant there was countywide sharing of any learning from incidents related to the bowel-screening programme.

Learning, continuous improvement and innovation

Staff felt empowered to contribute to service development. There was a clear focus on looking for potential innovative solutions to continue to ensure the delivery of high quality care. Staff and managers felt there was scope and a willingness among the team to develop services. There was good flexibility and things were implemented quickly. Staff were engaged as they could see things happening.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure all patient records are stored securely to maintain patients confidentiality.

Action the provider SHOULD take to improve

- Review processed to improve compliance with infection prevention and control. This should include improving hand hygiene compliance and environmental cleaning audits
- Re-affirm the importance of conducting all aspects of the WHO checklist.
- Follow national guidance for the receipt of controlled medicines to ensure a complete audit trail.
- Review processes to assess and record comfort scores for all patients receiving endoscopy procedures.
- Improve training compliance with dementia awareness, Mental Capacity Act and Deprivation of Liberty Safeguards to meet local targets.
- Enhance participation in national audits to enable benchmarking of practice.
- Review processes for the recording of additional contemporaneous documentation about decision making records in accordance with national guidance.
- Review processes to flag up communications needs to achieve full compliance with the Accessible Information Standards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Patient records were not always stored securely. This meant that unauthorised people (other staff, patients or their relatives) could gain access to confidential information about patients. Regulation 17(2)(c):