North East London NHS Treatment Centre

Quality Report

King George Hospital, Barley Lane
Ilford IG3 8YB
Tel:
Website:

Date of inspection visit: 22 - 23 January 2019
Date of publication: 04/04/2019

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

Ratings

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

Overall summary

North East London NHS Treatment Centre is operated by Care UK. The service has six operating theatres, one endoscopy suite, 22 bedded inpatient ward (Kingfisher), two post anaesthetic care units consisting of five recovery bays, day surgery unit with 23 patient bays, onsite pharmacy and outpatients department (eight consulting rooms).

The service provides surgery, outpatients and diagnostic imaging. We inspected surgery and services for outpatients and diagnostic imaging. Although the service did provide some diagnostic services such as ultrasound on site, the bulk of the diagnostic service is outsourced to other external providers and was therefore not included in this inspection.

Summary of findings

We inspected this service using our comprehensive inspection methodology, which we carried out on an unannounced inspection on 22 and 23 January 2019.

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.

Our rating of this hospital/service improved. We rated it as **Good** overall.

We found good practice in relation to outpatient care and surgery:

- The service had taken action to ensure that the World Health Organisation's Five Steps to Safer Surgery checklist was embedded in the theatre routine.
- There was a positive learning culture throughout the service. Staff were encouraged to report incidents and near misses. Learning from incidents was cascaded to staff both within the service and across the provider as a whole. The service reported no never events and had minimal serious incidents.
- All staff had up to date mandatory training.
- Cleanliness and infection control policies and controls were in place, including for the environment.
- Patient records were completed consistently and to a high standard.
- Safeguarding processes and training were in place and staff demonstrated good knowledge of these.
- The service demonstrated effective internal and external multidisciplinary (MDT) working.
- The service benchmarked patient outcomes to ensure the best standards of care. Outcomes were in line with national expectations. We saw procedures had been developed in line with national guidance and staff were aware of how to access them on the shared drive and intranet.
- Staff were competent to carry out the role for which they were employed and were supported to do so. The service developed staff with specialist skills to enable them to provide nurse led clinics. All staff had completed their appraisals and performance development plans.
- Most specialities offered evening and weekend clinics which facilitated patient access to appointments at times which suited their needs. The service offered patients 24 hours seven days a week advice line.
- All staff including consultants demonstrated empathy and compassion with patients in the context of the sensitive nature of many of the procedures carried out and provided emotional support. Staff spoke about patients with care and compassion, demonstrating genuine concern for their wellbeing.
- Patients told us they felt listened to by health professionals, and felt informed and involved in their treatment and plans of care.
- Access and flow through the service was generally highly effective.
- The service reflected and responded to the needs of local people through the provision of information in a range of languages and the use of face-to-face interpreters.
- The service worked collaboratively with the CCG and the local trust next door to reduce waiting times. Services were planned and delivered in a way that met the needs of the local population.
- The service had reduced their 'do not attend' rates by implementing a pre-appointment call in addition to text reminders.
- There was a clear vision and strategy for the service of which staff were aware.
- The leadership team recognised areas for improvement since the inspection of September 2016 and had taken proactive steps to address them. The leadership team continued to recognise the need for improvement and was working to deliver this.
- Generally there was a positive culture throughout the service. We found highly dedicated staff who were positive, knowledgeable and passionate about their work.
- Although some members of the senior leadership team were relatively new, senior leaders told us the team felt more stable.
- The centre suspended cinical activity bi-monthly for quality governance and assurance meetings and all staff were invited to attend.

Summary of findings

- Staff we spoke with said, they felt they could raise concerns and were confident that they would be dealt with appropriately.
- We saw evidence of public and staff engagement. The centre demonstrated and confirmed that patient experience was the key factor for their service development.

We found areas of practice that require improvement in relation to outpatient care and surgery:

- There were communication issues between the bookings team and the theatre team as well as between the theatre team and the recovery team which had the potential to impact on the delivery of an effective service.
- The risk register was not always directly related to specific risks within the service itself, but reflected generic or specultative risks.
- Due to patients sometime undergoing surgery with a different consultant than the one who had undertaken their consultation, difference of clinical opinion had the potential to impact on whether a patient received the same treatment for which they had initially been booked, or was treated at all.
- The fridge log was not completed regularly and we found several omissions.
- Although the service had an Infection Prevention and Control policy for Carbapenamase producing Enterobacteriaceae (CPE), staff awareness was inconsistent.
- Although the service had made some improvements to friends and family test scores, further improvement was required to increase the response rate.
- Although most staff we spoke with demonstrated awareness of the senior leadership team, some staff were not aware of the senior leaders' names or roles.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South East)

Summary of findings

Contents

Good

North East London NHS Treatment Centre

Services we looked at
Surgery; Outpatients

Summary of this inspection

Background to North East London NHS Treatment Centre

North East London Treatment Centre (NELTC) is located on a large campus in North East London that also contains an acute NHS hospital, a NHS community and mental health trust and a large care home. Patients attended pre-surgery clinics, pre-assessment, surgery and post-operative follow-up appointments in the same building. The service has six surgical theatres, 22 in-patient beds (Kingfisher Ward) and 24 day-case beds in the day surgery unit. The service had eight clinic rooms on-site for outpatient appointments and some ENT outpatient clinics also took place at GP health centres located at Hornchurch and Ilford.

NELTC opened in March 2007. NHS treatment centres are private-sector owned and are contracted to treat NHS patients free at the point of use. In 2014, the treatment centre was acquired by Care UK Clinical Services Ltd, the largest independent provider of NHS services in England. The hospital has had a registered manager in post since January 2019.

NELTC provided inpatient and day case elective surgery with associated outpatient and diagnostic clinics across seven disciplines: Orthopaedics, general surgery, ophthalmology, urology, gynaecology and ears, nose and throat (ENT). The service also offered a Joint Advisory Group (JAG) accredited endoscopy service. It provided services to people living in North East London and Essex. The model of care focuses on treating adults who are generally healthy and who do not have significant co-morbidities. It did not provide treatment to and care to children, nor did it provide treatment for 16 – 18 year old young adults.

The CQC last undertook a comprehensive inspection of the service in September 2016 when it was rated as 'requires improvement' overall. We inspected Surgery and Outpatients. Following our last inspection in September 2016 we issued one requirement notice requiring the service to take action to remedy breaches to Regulation 17 (2) (b), in relation to risk management in the surgical service and issued 15 actions the provider should take to improve. During this inspection, the service had dealt with or shown improvement for the previously reported concerns.

Our inspection team

The team that inspected the service comprised two CQC lead inspectors,two other CQC inspectors providing support, and four specialist advisor with expertise in surgery, endoscopy, and outpatient services. The inspection team was overseen by Keith Mahon, CQC Inspector.

Information about North East London NHS Treatment Centre

North East London NHS Treatment Centre (NELTC) is an independent healthcare service provided by Care UK. It is commissioned to provide elective surgical procedures under contract to a local acute NHS trust in the North East London area. The contract encompasses orthopaedics, gastroenterology, ophthalmology, oral surgery, endoscopy and general surgery specialities. Neurosurgery was provided onsite by surgeons from the local NHS trust under a Service Level Agreement (SLA), with NELTC staff providing theatre and recovery support.

To be accepted in to the service, patients must not require complex surgery or prolonged inpatient rehabilitation or have a chronic disease that would require immediate post-operative care in an ITU, must not have sickle cell anaemia, complex clotting disorders or significant renal failure, must not have suffered a myocardial infarct, undergone coronary artery bypass surgery or coronary stenting in the last 6 months or have

Summary of this inspection

suspected cancers,must not have a Body Mass Index of more than 40 or be less than 19 years old. The service also does not accept any patients for surgery with a clinical emergency.

Outpatient activity includes first appointments and follow up appointments in relation to these procedures. Between August 2017 and July 2018 the centre reported 12461 first attendances and 11099 follow up appointments within outpatients. From these, 99.9% of attendances were NHS funded.

We inspected all areas of the treatment centre over a two day period. This included Kingfisher Ward, the day case ward, pre-assessment clinics, theatres (including the dedicated theatre for endoscopy and adjoining decontamination suite), and waiting areas. We did not inspect the diagnostics service as this was supplied by another provider.

During the inspection visit we spoke with 24 patients, including with their family members and carers, and 50 staff members including nurses, doctors, consultants, senior managers, therapists, and other support staff. We also observed interactions between patients and staff, and looked a randomised selection of 17 patient care records. Information provided by the provider prior to our inspection was reviewed and used to inform our inspection approach.

Services accredited by a national body:

- Joint Advisory Group on GI endoscopy (JAG) accreditation

Services provided at the hospital under service level agreement:

- Pathology services
- Microbiology
- Blood Transfusion
- Radiology Services and PACS
- Sterile services
- Patient catering and Cleaning services
- Laundry services
- Facilities Management
- Biomedical Engineering
- Patient transport

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?

Good

Our rating of safe improved. We rated it as **Good** because:

- The service had taken action to ensure that the World Health Organisation's Five Steps to Safer Surgery checklist was embedded in the theatre routine.
- Staff adhered to best practice in respect of infection prevention and control.
- There was a positive learning culture throughout the service. Staff were encouraged to report incidents and near misses. Learning from incidents was cascaded to staff both within the service and across the provider as a whole.
- The service reported no never events and had minimal serious incidents.
- All staff had up to date mandatory training and the records of those who worked under practising privileges were monitored.
- Cleanliness and infection control policies and controls were in place, including for the environment.
- Patient records were completed consistently and to a high standard.
- Safeguarding processes and training were in place and staff demonstrated good knowledge of these.
- The centre's infrastructure and equipment was replaced, renewed and refurbished on a rolling basis.

However:

- The fridge log was not completed regularly and we found several omissions.
- We found some disposable curtains did not have a replacement date which meant it was difficult to determine when they had been last changed.
- Although the service had an Infection Prevention and Control policy for Carbapenamase producing Enterobacteriaceae (CPE), staff awareness was inconsistent.

Are services effective?

Good

Our rating of effective stayed the same.We rated it as **Good** because:

- The service demonstrated effective internal and external multidisciplinary (MDT) working.
- The service benchmarked patient outcomes to ensure the best standards of care. Outcomes were in line with national expectations.

Summary of this inspection

- Staff were competent to carry out the role for which they were employed and were supported to do so.
- We saw procedures had been developed in line with national guidance and staff were aware of how to access them on the shared drive and intranet.
- The service developed staff with specialist skills to enable them to provide nurse led clinics.
- All staff had completed their appraisals and performance development plans.
- Most specialities offered evening and weekend clinics which facilitated patient access to appointments at times which suited their needs.
- The service offered patients 24 hours seven days a week advice line.
- The service had renewed their JAG accreditation in June 2018.

However:

- There were communication issues between the bookings team and the theatre team as well as between the theatre team and the recovery team which had the potential to impact on the delivery of an effective service.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- All staff including consultants demonstrated empathy and compassion with patients in the context of the sensitive nature of many of the procedures carried out and provided emotional support.
- Staff spoke about patients with care and compassion, demonstrating genuine concern for their wellbeing.
- All results from the ongoing patient feedback questionnaire indicated staff consistently involved patients in their care and treatment.
- Policies and training standards were in line with the National Institute for Health and Care Excellence (NICE) quality statement 15 in relation to dignity and kindness.
- Patients told us they felt listened to by health professionals, and felt informed and involved in their treatment and plans of care.

However:

- Although the service had made some improvements to friends and family test scores, further improvement was required to increase the response rate.

Summary of this inspection

Are services responsive?

Good

Our rating of responsive stayed the same.We rated it as **Good** because:

- Access and flow through the service was generally highly effective.
- The service was meeting its referral to treatment time targets.
- The service reflected and responded to the needs of local people through the provision of information in a range of languages and the use of face-to-face interpreters.
- The service had addressed concerns raised by both staff and patients regarding car parking.
- The service worked collaboratively with the CCG and the local trust next door to reduce waiting times.
- The service had reduced their 'do not attend' rates by implementing a pre-appointment call in addition to text reminders.
- Services were planned and delivered in a way that met the needs of the local population.
- The service monitored waiting times for the one stop clinics and had demonstrated improvement in the data provided in average clinic times.
- The service monitored waiting times for diagnostic imaging and had reviewed their service level agreements to improve patient pathways.

However:

- Due to patients sometime undergoing surgery with a different consultant than the one who had undertaken their consultation, difference of clinical opinion had the potential to impact on whether a patient received the same treatment for which they had initially been booked, or was treated at all.

Are services well-led?

Good

Our rating of well-led improved.We rated it as **Good** because:

- There was a clear vision and strategy for the service of which staff were aware.
- The leadership team recognised areas for improvement since the inspection of April 2017 and had taken proactive steps to address them. The leadership team continued to recognise the need for improvement and was working to deliver this.
- Generally there was a positive culture throughout the service. We found highly dedicated staff who were positive, knowledgeable and passionate about their work.
- Although some members of the senior leadership team were relatively new, senior leaders told us the team felt more stable.

Summary of this inspection

- Staff we spoke with described the culture as friendly and wonderful.
- The centre suspended cinical activity bi-monthly for quality governance and assurance meetings and all staff were invited to attend.
- Staff we spoke with said, they felt they could raise concerns and were confident that they would be dealt with appropriately.
- We saw evidence of public and staff engagement. The centre demonstrated and confirmed that patient experience was the key factor for their service development.

However:

- The risk register was not always directly related to specific risks within the service itself, but reflected generic or specultative risks.
- Although most staff we spoke with demonstrated awareness of the senior leadership team, some staff were not aware of the senior leaders' names or roles.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

Our rating of safe improved.We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

All staff were expected to complete their mandatory training on an annual basis. Mandatory training was organised and monitored by the ward managers and the theatre manager. Where an individual member of staff's mandatory training was not up-to-date this would be discussed at their appraisal and it was the responsibility of their line manager to ensure that training was arranged in sufficient time.

During our inspection, the theatres were not in use for one day as part of a planned pause in activity to allow staff to catch up on their mandatory training, with face-to-face sessions provided on manual handling and additional training on caring for patients with malignant hypothermia.

All staff completed mandatory training in respect of resuscitation, PREVENT (Prevent is part of the UK's Counter Terrorism Strategy known as CONTEST. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity), the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS), Safeguarding Children Level 2, Safeguarding Adults Level 2, health and safety, infection prevention and control, patient consent and clinical governance. Clinical staff completed additional mandatory training in moving and handling and chaperoning patients, whilst administrative staff completed additional mandatory training in basic life support.

Data provided by the service showed the overall staff compliance rates were: basic life support (BLS) e-learning (96.55%), BLS (88.68%), immediate life support (88.06%), advanced life support (ALS), Health and Safety Executive (HSE) for employees (94.9%), fire awareness and safety (69.20%), moving/lifting patients (94.4%), moving/lifting patients practical (79.84%), chaperone (97.06%), infection prevention and control (IPC) e-learning (91.24%), IPC practical (97.67%), clinical governance (91.95%), equality and diversity (87.74%) and information governance (89.67%). During our inspection, the lead nurse told us the compliance for fire awareness and safety was now 100% for outpatient (OPD) staff. The provider told us that additional training sessions had been planned in order to address the areas in which training rates fell below the target rate.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The service had up-to-date policies for safeguarding adults and children available to staff via the intranet.

There were two safeguarding leads who were trained to level four safeguarding for both adults and children. One of the safeguarding leads told us that she had recently undertaken "train the trainer" training in order to cascade her knowledge to staff. Staff were aware of the safeguarding lead and how to contact her.

Good

Surgery

At the time of our inspection, the safeguarding lead was preparing a level three safeguarding adults and children course for all clinical staff. She told us that this course would place particular emphasis on female genital mutilation (FGM) and the government's PREVENT strategy, to recognise and stop individuals from getting involved or supporting terrorism or extremist activity.

The safeguarding lead said that she had good working relationship with colleagues in the local authority safeguarding team.

Data provided by the service showed the overall staff compliance rates for all departments were Prevent training (96.82%), Safeguarding Children level one (92.86%), Safeguarding Adults level one (96.15%) and Safeguarding Adults level two (96.9%).

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

All of the ward and theatre areas were kept clean and clutter free. We observed domestic staff undertaking ward cleaning rounds, and responding to requests for spillages to be cleaned. Domestic staff completed cleaning schedules to indicate they had cleaned all relevant areas to the required standard.

Theatre staff kept theatres clean and we observed them decontaminating the theatre and anaesthetic rooms after each patient.

During our inspection in April 2017 we found that Methicillin-resistant Staphylococcus aureus (MRSA) screening was not routinely carried out for all surgical patients who were pre-assessed at the nearby NHS Trust as per Department of Health guidelines. However, at this inspection, MRSA screening was documented in all of the patients' notes we looked at. Staff told us that MRSA screening was now routine practice.

The service reported no cases of MRSA or Colostrum difficile (CDiff) between July 2017 and August 2018.

The service had up to date infection prevention and control policies in place. Staff were able to access the policies via the intranet.

There was a lead infection prevention and control (IPC) practitioner, who was responsible for training staff and carrying out regular ad hoc hand hygiene audits.

All staff adhered to best practice in respect of hand hygiene. We observed staff routinely sanitising their hands between patients and on entering and leaving wards.

All of the staff observed the bare below the elbow protocol to reduce the risk of infection.

We had sight of the hand hygiene audits for theatre for November and December 2018 and January 2019 which indicated 100% compliance.

There were quarterly decontamination audits for theatres and the wards. The audits for January 2019 indicated 100% compliance.

There were clearly marked boundary lines marked on the theatre floors indicating sterile areas where staff were required to wear scrubs. During our inspection, all staff followed this requirement.

All of the curtains we checked had been replaced within the appropriate time frames.

At the entrance to the Kingfisher and day wards there were specialised door handles which dispensed hand sanitising gel, meaning that all visitors to the ward were required to use the hand sanitiser.

In addition, hand sanitisers were available to staff, patients and visitors throughout ward areas and there were antiseptic wipes for cleaning surfaces after use. We observed a nurse sympathetically challenging a visitor who had not used hand sanitising gel on entering a ward.

Patients were proactively encouraged to engage with the service's IPC strategy. The information packs provided to each inpatient on admission included information on IPC best practice and encouraged patients to challenge staff as to whether they had washed their hands before and after touching them. There were regular patient-led hand hygiene audits, in which patients were asked about staff hand washing and use of PPE. We were provided the patient led audit for June 2018, completed by 12 patients, which indicated 100% compliance.

IPC was a standing item of the agenda at the clinical governance meetings. In addition, there was an annual IPC action plan, which was reviewed on a quarterly bases.

Good

Surgery

There was one surgical site infection in the reporting period of November 2017 to October 2018.

Staff used green 'I am clean' stickers to indicate when equipment had been cleaned following use.

The service participated in Care UK's antibiotic stewardship programme to promote the appropriate use of antibiotics in order to restrict their overuse and the risk of infections and bacteria adapting and becoming resistant to some antibiotics.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The environment was clean and clutter free. Corridors were kept clear of large equipment and fire escapes were clearly marked and accessible. Where it was necessary to store equipment in the lobby of the theatre suite, this was done in such a way as not to restrict access to the stairs. There were reminders for staff regarding the storage of this equipment on the wall in the lobby.

There was a theatre stores technician who was responsible for the maintenance of consumables for theatre. These were stored appropriately and regular stock takes undertaken. Theatre staff told us that the supply of consumables was reliable.

There was a resuscitation trolley on both of the wards and in the theatre suite. The trolleys were fully stocked at the time of our inspection and all of the consumables in date. Nursing staff signed to say that they had checked the tamper seal on the trolley each day and monthly stock checks were undertaken. In addition, there was a difficult airways trolley in the theatre suite which was kept fully stocked with all consumables in date.

There were two theatres with laminar flow which were used for patients at increased risk of infection.

Sterilisation of theatre equipment was provided off-site by an outside organisation. Theatre staff told us that they had a good relationship with the sterilisation company and equipment was readily available.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

In theatres, we observed staff carrying out the World Health Organisation (WHO) five steps to safer surgery checklist. The WHO checklist is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from the theatre.

WHO checklists were fully completed and documented in the eight patient notes we reviewed.

The service audited the completion of the WHO checklist. The service achieved 100% completion rates for WHO checklists in the October 2018 audit.

During our last inspection in April 2017, it was identified that the pre-operative team brief was not being completed rigorously with input from all staff. However, on this inspection, we observed three pre-operative briefings all of which were completed meaningfully, with involvement and input from all staff involved in the procedure.

During our last inspection staff told us that theatre debriefs did not always take place and were not a fully embedded part of practice. On this inspection, we found this had improved as staff told us that the debriefs were routinely completed following surgery and that all staff were involved in the process.

Risk assessments, for example for a patient's risk of falls, were undertaken on each patient on admission to the wards and documented in patient notes.

There was a sepsis pathway in place for patients, and sepsis kits available on the wards.

Nurses completed National Early Warning Scores (NEWS) to monitor patients' vital signs such as blood pressure, pulse and breathing rates on the ward. Where a patient scored four or more, the Resident Medical Officer (RMO) would be called to assess the patient, and if necessary prescribe further appropriate medication or authorise the transfer of the patient, to the local NHS hospital, in the event of an emergency, in accordance with a Service Level Agreement. The completion and use of the NEWS score was audited and we saw evidence that patients had been escalated as a result of their Ffive

In addition, the lead nurse on each shift could contact the RMO if they had concerns about a patient.

RMOs told us that they had access to advice and support from patients' named consultants during working hours

and from the on-call consultant out of hours. In addition, they could request the consultant to attend to assess the patient where they were not of the view that an immediate transfer was necessary.

Nursing and support staffing

The service ensured that for each shift it had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The hospital's lead nurse was responsible for nurse staffing in the surgery department. There was a matron for the inpatient service and one for the day surgery unit. There was always a nurse in charge on each shift.

The service calculated core staffing requirements in accordance to budgeted workload. Where necessary for patients with additional needs, an additional healthcare assistant (HCA) would be scheduled to provide one-to-one care to the patient.

Planned and actual staffing levels were displayed daily on each of the wards. During our inspection both wards were fully staffed.

The surgery service had a vacancy rate of 32% for qualified nursing staff, which equated to 4 full time equivalent staff members. Staffing numbers were made up through the use of bank and agency staff. In October 2018 the rate of bank and agency staff usage was 26%. Senior staff told us that they made efforts to fill shifts with bank staff before using agency staff and that, where agency staff were used, they tried to use the same staff who were familiar with the service.

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

Surgical treatment at NELTC was consultant led. There was a stable cohort of consultant surgeons and anaesthetists working in the surgery service and many doctors we spoke with had worked at the trust for many years.

There were 19 consultants who were employed on either a permanent or part time contracts, all of whom had been undertaking work at the hospital for over 12 months. Consultants' contracts were reviewed by the medical director.

We were told that consultant care was available 24 hours a day, seven days a week. All of the consultants were within 30 minutes of the hospital. There was an on-call rota to ensure their availability. Consultants who were not local to the service were provided with accommodation on site during their on-call hours. Staff we spoke with said that issues with consultant availability were very rare.

Twenty four hour, seven day medical cover was provided by one of the two RMOs employed by the service. There was an RMO on site at all times. RMOs undertook regular duties including ward rounds and patient discharge assessments between 7am and 11 pm. Between 11pm and 7am, they had protected time for sleep, however, they were available during this time also in the case of patient deterioration. In addition, they had protected break times. There were arrangements in place for additional RMO cover during the day to allow an RMO to catch up on sleep where they had had a particularly disrupted night.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

There was a records management policy. This was up-to-date and available to staff via the intranet. Patients' records were managed in accordance with the Data Protection Act 1998.

Records were kept securely in locked cabinets in ward areas.

One patient told us that their appointment had been cancelled as a result of their records being unavailable at the time of their scheduled surgery in 2018. Staff told us that this occurred far less frequently since the introduction of the new records management policy.

The records storage system had been recently reconfigured. Medical records were stored off site at one of the provider's other treatment centre in Gillingham. The senior leadership team told us the reconfiguration highlighted that internal processes for booking the records in and out required embedding. Staff told us no patients records went missing. The service used a web-based programme to track the location of the records at all times. There was a staff member appointed to check the notes

ahead of surgery to ensure the notes were complete and included any recent test results. Staff told us these checks were done one week in advance which allowed enough time to get any missing information if identified.

The service had corporate policies for clinical written documentation, records retention and archiving policy. in addition there was a patients records image storage policy.

The service archived all medical records six months after the patient's last episode of care. If the patient returned for any reason, the centre could request the records from archiving to be securely returned. The records were securely transported in medical notes boxes and delivered in the service's own transport with their employed driver.

We checked 10 sets of patient records. They were clearly, fully and appropriately completed. Patient notes covered the entirety of the care pathway, from pre-assessment to discharge. Where relevant, the notes documented assessments from across the multi-disciplinary team. Nursing staff completed risk assessments for patients, for example, falls assessment and mitigating actions were recorded in the notes. There were quarterly location-wide documentation audits where 10 sets of patient records were checked for security, patient identifiers, alterations and allergies.

Where patients had allergies this was clearly recorded on the front of their records.

Patients were provided with copies of their discharge notes and these were also forwarded to their general practitioner.

During our last inspection we highlighted a concern in respect of patients' consent forms featuring no other identifying feature than the patient's signature, leading to potential confusion if the notes became lost or detached. On this inspection, we found the service had addressed this, with patients' names written onto the forms.

We observed all staff locking their computer screens when leaving them.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

There was a safe and secure handling of medicines policy, which we had sight of. The policy had been reviewed in line with the stated review date. Staff were able to access the policy by the intranet.

Controlled drugs (CDs) (medicines which are controlled under the Misuse of Drugs Act (1971) (and subsequent amendments)) were appropriately stored in locked safes, with the nurse in charge on each of the wards holding the key. CDs were checked daily to ensure that the stock was accurately reflected in the relevant CD books.

All CDs were appropriately signed for in the CD books, with two registered nurses signing to indicate that the CD had been administered or else destroyed.

There was a quarterly medicines management audit completed by the pharmacy team. We had sight of the audit for November 2018, which indicated 95% compliance in respect of staff fulfilling their responsibilities and appropriately prescribing; 94% in respect of recording administration, errors, incidents and recall of medicines; 96% in respect of compliance with controlled drugs policy and 95% in recording of stock control across the service as a whole. The service's target compliance rate was 90%. The only area of non-compliance in respect of CDs recorded in the audit related to a lack of process for recording, registering and storing patients' own CDs and in staff training in respect of CDs. The pharmacy lead told us that following the audit, additional training had been provided to nurses in respect of CDs and a process had been introduced for the recording and storing of patients' own CDs. This was confirmed in the action plan arising from the audit.

Where patients brought their own CDs to the service during an overnight stay, these were appropriately labelled and stored in the CD cupboard, and logged in a separate CD book.

Medicines requiring refrigeration were appropriately stored and staff recorded fridge temperatures daily.

There was only one medicines incident in the last three months and this related to a patient receiving an additional dose of paracetamol. This was investigated and classified as a no harm incident. Staff were reminded to double check medicines administration records.

On admission to the wards, staff completed a medicines reconciliation document, to record patient's existing

medicine routines and to ensure that they had sufficient medicine with them for the duration of their stay. The completion of medicines reconciliation was audited on a quarterly basis. The audit for November 2018 indicated 100% compliance.

To take out (TTO) medicines, for patients to take with them on discharge, was prepared by the pharmacy team in advance of patient discharge. Ward staff said they rarely had any difficulty in obtaining TTOs for patients prior to their discharge. They said that were there any issues with a particular medicine being out of stock they would ask for the patient to be provided with a prescription by the RMO or consultant anaesthetist or for the patient to return the next day to collect their TTOs.

Staff described a good working relationship with pharmacy colleagues. They said that pharmacy staff were accessible and helpful.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and generally shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. The service reported did not report any never events in the reporting period August 2017 to July 2018.

We were provided with a list of reported incidents in the surgery department for the period November 2018 to January 2019. In that period there were 16 incidents reported, of which two were graded “moderate risk” and eleven graded “low risk”, the other incidents were classified as “no harm”. Each of the incidents had an outcome recorded against it which indicated what action had been taken to prevent similar incidents occurring in future.

There was a Never Event on 15 July 2017, prior to the reporting period, where a a foreign object was retained in a patient following surgery. This incident was reported a serious incident to the NHS’s strategic executive information system (STEIS) and a root cause analysis (RCA) was completed at the service. We had sight of the RCA completed by the medical director in September 2017, which indicated that the incident had been dealt with appropriately. The RCA detailed learning from the incident including a decision that all patients undergoing the same procedure in future should undergo an x-ray and that whenever a component of surgical equipment was missing no assumption should be made as to its whereabouts. The action plan included a re-iteration of the importance of the WHO checklist. Theatre staff we spoke with were aware of this incident and the learning from it.

There was a generally a good incident reporting culture within the service. Staff reported incidents and near misses through an electronic incident reporting system. Incidents could then be escalated to relevant senior staff for investigation. All of the staff we spoke with told us that they knew how to report an incident and felt confident to do so. Most of the staff we spoke with told us that they had reported at least one incident or concern during their time working for the service. They said that when they did so, they heard back following investigation of the incident.

Staff were able to describe incidents which had occurred and changes in practice brought about as a result. This included incidents which had occurred at other sites operated by the provider.

Reviewing incidents was a standard agenda item on the monthly clinical governance meetings and we saw evidence of this from meeting minutes. This ensured that any themes of incidents were highlighted and new incidents discussed.

The surgery service lead told us that Our morbidity and mortality reviews take place at either Quality Governance Assurance (QGA) or at the weekly anaesthetics team meetings. We were provided with the minutes of the last three QGA meetings, which indicated that the team discussed any patient safety incidents from across Care UK; any patients who may have developed complications; any unplanned patient readmissions; any returns to theatre; any 'Never Events’ either from across Care UK and learning from everyday examples of excellent care.

Regulation 20: Duty of candour (DoC), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the organisation to notify the

relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Staff we spoke with had a clear understanding of the DoC and the responsibilities it entailed. We had sight of the service's DoC policy, which was detailed and up to date. In addition, the electronic incident reporting system included prompts to remind staff of the DoC where relevant.

Safety Thermometer (or equivalent)

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is a national tool used by the NHS for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter, surgical site and urinary tract infections and venous thromboembolism (blood clots in veins). There was one surgical site infection in the period fromJuly 2017 to September 2018.

At our inspection of April 2017, metrics from the safety thermometer were displayed prominently on noticeboards in each of the wards. However, at this inspection, safety thermometer results for the previous quarter were clearly displayed on noticeboards in the ward corridors.

Are surgery services effective?

Good

Our rating of effective stayed the same.We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Staff had access to up-to-date policies and procedures as well as national guidance via the intranet. Policies and procedures were based on best practice from the National Institute for Health and Care Excellence (NICE), the Royal College of Nursing (RCN) and other relevant bodies. We saw that all of the policies were regularly reviewed in line with their review dates.

We observed staff carrying out their duties in accordance with national guidelines and best practice recommendations, for example enhanced recovery after surgery (ERAS) in knee and hip replacement surgery. The enhanced recovery programme aims to improve patient outcomes and speed a patient's recovery after surgery.

There were regular audits conducted across the service. In addition there was a provider-wide audit programme which reviewed individual clinician's practice and provided a benchmark against other Care UK clinicians nationally.

Within the theatre, we observed that staff adhered to the NICE guidelines clinical guidance 74 related to surgical site infection prevention, and staff followed recommended practice. This guideline offered best practice advice on the care of adults and children to prevent and treat surgical site infection. For example, we observed the patient's skin at the surgical site was prepared immediately before incision using an antiseptic (aqueous or alcohol-based) preparation.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

There was a process in place to ensure patients appropriately fasted prior to undergoing a general anaesthetic. Patients were asked to confirm when they last ate and drank during the checking-in process on arrival to theatre. The amount of time patients were kept nil by mouth prior to their operation was kept to a minimum, patients were allowed to drink clear fluids up to two hours prior to their operation and patients having operations in the afternoon were told they could have an early breakfast, this was in line with best practice.

The Malnutrition Universal Screening Tool (MUST) is a tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. MUST scores were completed by nursing staff on the wards to assess patients' risk of being under nourished. The records we reviewed had a nutrition and hydration assessment undertaken.

There was fresh water available and in reach beside each patients' bed or chair. In addition, there were posters indicating the recommended amount of water that should be drunk each day, with this broken down into simple units, for example jugs, mugs and glasses.

We observed catering staff offering day surgery patients tea, coffee and snacks whilst they were waiting for discharge.

Catering staff were responsible for ensuring patients' dietary requirements and preferences were met. We had sight of the menu, which catered for a wide range of diets. Patients consistently rated the food above 90% in the last year.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We saw from patients' pre-assessment notes that post-operative pain relief options were discussed and planned at the pre-assessment stage. This meant patients could continue to receive appropriate pain relief on their arrival on the ward without delay.

Staff made use of a range of pain scoring systems in order for patients to communicate their level of pain. This included numeric scoring and pictures which patients could point to express their level of pain.

We observed a consultant anaesthetist discussing a patient's pain relief with them during the ward round and amending their prescription in response to concerns about the side effects of the pain relief initially prescribed for the patient. There was a range of pain relief options available, including patient controlled analagesia.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The service submitted outcome data to the NHS's Patient Reported Outcome Measures (PROMS) platform. This allowed the service to be benchmarked against other providers.

We were provided the provisional PROMs data for the period April 2017 to March 2018. The data indicated that the service was not an outlier for patient outcomes in any surgical specialties in any of the metrics.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

The hospital had in place appropriate job descriptions used for staff recruitment. Recruitment checks were made to ensure new staff were appropriately experienced, qualified and suitable for the post.

Managers monitored staff members' registration status by a local electronic database. Managers told us it was the responsibility of individual staff memebers to make sure their registration was up to date. However, they supported nursing staff undergoing revalidation with the Nursing and Midwifery Council (NMC).

There was a clinical supervision policy in place for non-medical staff, which aimed to support staff to meet the requirements of their role.

The service had a comprehensive induction checklist for all new employed staff, which included locum and bank staff. The induction checklist was completed over 12 weeks and included what to do before the start date and day of arrival, mandatory training, safeguarding including PREVENT, opportunities to raise any concerns or issues, communication and information technology. The mandatory training section had to be completed within the first two weeks. All staff received a local induction which included meeting all the departments and service leads.

The medical director was responsible for ensuring the competencies of all consultants working in the service. In addition, consultants who were also employed elsewhere were required to provide Care UK with evidence of relevant ongoing training, supervision and training with their primary employer.

Where agency staff were used, the head of nursing told us that the hospital tried to use the same agency staff that were familiar with the environment.

All permanent staff underwent a yearly appraisal. In the year to December 2018, 100% of nursing staff had

undergone their appraisals, compared with only 66% of healthcare assistants and 70% of other staff. Efforts were being made to ensure that all staff underwent appraisal in the current year. Staff who had had their appraisal described it as relevant and meaningful.

Multidisciplinary working

Staff of different kinds usually worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

We observed good MDT working. Ward rounds were interdisciplinary with the RMO, consultant anaesthetist, physiotherapists and nursing staff taking part. In addition, physiotherapists and the RMO were involved in the nursing handover.

Operating department practitioners (ODP)s told us that they were fully integrated within the theatre team.

Clinicians of all disciplines attended the weekly theatre users' group which had been established in December 2018.

The service had numerous Service Level Agreements (SLA) for the provision of services by or in conjunction with other providers, in particular, the local trust, with whom they shared a campus.

Under a surgical SLA, the local trust undertook neurosurgery in the service's theatres. The surgery was carried out by the local trust's surgeons supported by the service's theatre staff, with patients being recovered and monitored post-operatively on site. We had sight of the SLA concerning neurosurgery, which made clear the different responsibilities of each service in providing care to patients.

The medical director for surgery told us that as part of the agreement, he carried out checks on the surgeons who came from the neighbouring NHS trust to deliver services, reviewing qualifications and competencies before they would be cleared to undertake procedures on site. External consultants were required to adhere to the service's policies whilst on site. The medical director described an incident where an external surgeon had been due to operate on a patient who did not speak English, when one of the ward HCAs observed the consultant attempting to obtain consent from the patient without the use of a translator, they escalated this to the medical director who then spoke with the surgeon. As a translator had not been booked, the medical director refused to allow the procedure to continue and conveyed this to the patient through the use of a telephone translation service, he then revoked the right of the surgeon to practise within the service in future.

Senior staff told us that they had positive working relationships with services with whom they had SLAs.

Seven-day services

Surgery occurred five days of the week, Monday to Friday. Occasionally, when demand for services indicated the need, surgery was carried out on Saturdays. All other services were available seven days a week.

Pharmacy services were available on site five days a week from 08:00 – 16:00 hours. Outside of these hours the RMO & matron could access pharmacy to dispense medicines. An on-call pharmacist was available for advice out of hours. Staff reported they could access pharmacy advice at all times.

Physiotherapy services were provided within office hours seven days a week.

Health promotion

All patients were screened for their smoking status during their initial consultation and pre-asessment. Where patients were smokers staff directed the to to community services for support. Staff also gave advice to patients on weight reduction, regular exercise and diet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

There were up-to-date consent, Mental Capacity Act (2007) (MCA) and Deprivation of Liberty Safeguards (DoLS) policies in place. These were available to staff via the intranet. Consent, Mental Capacity Act (MCA) and DoLS training formed part of the mandatory training completed by all staff. The corporate safeguarding policy covered DoLS and the MCA. Data provided by the service showed the overall staff compliance rates was 93.4% for MCA and DoLS and 97.7% for consent, against a target of 95%.

Good

Surgery

Patients' treatment options, intended outcomes and attendant risks were made clear to them, meaning that consent was informed. Consent for surgery was only obtained by consultants. Initial discussions regarding consent were commenced by the consultant at the outpatient clinic stage. Once admitted, consent was reaffirmed with the patient by the operating consultant.

We had sight of a number of consent forms which appropriately detailed the risks and benefits to the procedures.

Are surgery services caring?

Good

Our rating of caring stayed the same.We rated it as **good.**

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We spoke with six patients, they said that staff were kind and compassionate and made time to attend to their needs. There were thank you cards from former patients displayed in each of the ward areas. Staff spoke about patients with obvious care and compassion.

We observed a ward clerk contacting a patient who had been discharged from the ward to provide them with the phone number of another former patient who asked that she pass it on, having formed a friendship whilst sharing a bay on the ward.

We observed a physiotherapist taking time out of the ward round in order to assist a patient who was in pain when moving position in bed.

Patients were asked to complete a written Friends and Family Test which could be returned to feedback boxes on the wards, to state whether they would recommend the service to their friends and family. Of the inpatients who completed the test in December 2018, 100% said that they would recommend the service. In October and November 2018, the figure was above 90%. In day surgery, 100% of patients who completed the test said they would recommend the service in October and December 2018, with over 90% recommending the service in November 2018.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Administrative staff told us that they could access the chaplaincy service from the local NHS trust to provide religious and emotional support to patients where appropriate which they recalled having done so on a number of occasions.

We observed a staff member reassuring a patient about their care and what to expect. Patients told us that staff always took time to answer their questions at put them at ease. There were leaflets throughout the hospital for patients detailing emotional support available from charities and support groups for patients with various conditions.

There was a room in the day ward set aside for discussions with patients and families receiving bad news.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

The majority of the patients we spoke with said that they had been kept informed about their care and their options for care. They said that, where appropriate, family members had been kept informed.

We observed a multidisciplinary ward round. All of the staff introduced themselves to each of the patients and any family members that were present. They spoke directly to the patient and avoided using jargon to ensure that the patient understood what was said. We observed a consultant anaesthetist discussing a patient's pain relief medication with them. They spoke at length with the patient and asked them about their personal routine before prescribing the course of medication most appropriate for them.

Are surgery services responsive?

Good

Surgery

Good

Our rating of responsive stayed the same.We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

The service worked with the clinical commissioning group (CCG) and the local trust to reduce waiting times for patients in specialities such as neurosurgery and endoscopy. The service had plans to extend this to orthopaedics and ophthalmology in the future. The service also worked with local referral management centres.

During our last inspection staff told us that they did not know how to access written information in languages other than English. On this inspection we found this had improved as staff told us written information was available in the languages most widely spoken in the local area. Staff had access to a computer programme which allowed them to print information in additional languages.

The service aimed to have all patients entering theatre within a maximum time of four hours from admission.

Meeting people's individual needs

The service took account of patients' individual needs.

The service had a policy of using face-to-face translation services. We observed translators' signatures in patient notes.

Information leaflets were displayed in patient waiting areas in a number of languages including English, Polish, Portuguese, Arabic and Mandarin. Leaflets and information in other languages could be printed on request.

Inpatients had access to meals to meet a range of religious dietary requirements, such as a Halal or Kosher diet. Patients' food allergies were noted by nursing staff on their admission to the hospital and provided to catering staff. In addition, catering staff visited patients and recorded their food preferences.

There was a welcome pack on each patients' bed prior to their arrival on Kingfisher ward. The pack included information about infection prevention and control, the service's values, patient privacy, fire alarms, and expected waiting times. In addition, the welcome pack included information on how to complain and patient satisfaction surveys and how to engage with the patient forum.

The service had a dementia strategy to deliver high quality, consistent care for patients wih dementia. This was a long-term project, meaning that training was being rolled out to all staff. Staff told us the service had assessment forms for dementia and mental health. The service encouraged family members and relatives to stay with dementia patients. The service had an information leaflet for patients with dementia and their carers which explained their stay in the centre.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were generally in line with good practice.

Overall, there was good patient flow through the service. Patients underwent clinical consultations at which options were discussed and decisions made about the best course of action to treat their condition. At that stage, patients gave initial consent to treatment.

We were provided with referral to treatment (RTT) data for each of the surgical specialities for the period November 2017 to December 2018. The data indicated that in orthopaedics, ophthalmology and gastroenterology there had been an improvement in RTT across this period. In urology, gynaecology there had been an improvement in RTT since September 2018, with waits between 12 and 14 weeks for admitted patients. In general surgery, there had been a worsening in RTT between August and October 2018 to up to 9 weeks, although this had come down to below 7 weeks in December 2018.

A number of theatre staff told us there was a lack of effective communication between the bookings team and the theatre team. A number of theatre staff told us that the lists were frequently longer than they were able to complete within the theatre opening hours, meaning they had to stay later to complete the list. They said that they had frequently reported this through the electronic reporting system but that there had yet to be any change. They said that they felt better able to assess how long a surgical list was likely to take but that contacting the bookings team had no impact. This had potential to lead to

day surgery patients having to stay overnight to avoid a late discharge or patients fasting for a prolonged period. The senior leadership team told us they were aware of this issue and were working to improve the bookings service by monitoring the bookings system. They said, however, that their priority was ensuring that patients were treated in a timely manner.

Patients were not always listed for surgery with the consultants who had undertaken their initial consultation on referral to the service. Theatre staff told us that this sometimes impacted on whether patients underwent surgery, as there were occasions when the consultant listed to carry out the procedure disagreed with the clinical decision of the initial consultant. In these instances, the surgeon would visit the patient on the ward and offer the patient an alternative procedure or recommend that they did not undergo the procedure for which they were listed. In these circumstances the patients had the option to cancel the procedure or, in some cases, to undergo the procedure for which they were originally listed. This had the possibility to impact on patients' confidence in the clinical decision making and had the potential to make patients feel pressured to make decisions about their care. Where patients chose not to undergo the treatment that they had been booked for this would impact on the individual patient's treatment journey and may result in a prolonged referral to treatment time if they subsequently decided to undergo the original procedure.

The medical director recognised this issue. He told us that where there was a difference in clinical opinion he encouraged the two consultants to discuss the issue at the time via telephone, although he recognised that this was likely to cause delays. In addition, he encouraged consultants to discuss cases retrospectively in order to reduce the number of such disagreements. However, whilst the service recognised the issues that changing consultants prior to a procedure created they said that they would work to mitigate the disruption rather than limiting the use of different consultants.

There were 62 procedures cancelled for non-clinical reasons in the period July 2017 to August 2018. Of those, 27% had surgery re-booked within 28 days. Surgical staff told us that there had been a reduction in the number of on-the-day cancellations since the last inspection although we were not provided with specific data in support of this.

Where patients were discovered to no longer to meet the inclusion criteria for surgery following having been admitted to a pathway they were discharged from the service. This had the potential to have a significant impact on the individual patient's journey, as it resulted in their being discharged back to their GPs, and therefore having to start their pathway from the beginning with a different provider. Senior staff told us that they were aware of this issue and were discussing it with the local Clinical Commissioning Group (CCG).

The service kept data on the number of referrals which did not convert into surgical interventions. They collected metrics on the number of patients referred into the pathway by their GPs who were deemed not suitable for surgery at the clinical assessment stage either as a result of the nature of their condition, or the patient not meeting the inclusion criteria for the service. This data could be broken down to identify themes in referrals that did not convert as well as by the particular GP who had made the referral. The service presented this data to the CCG. In addition, we were told that the service had started contacting GPs whose conversion rates were low to discuss the issue with them and remind them of the criteria for pathways offered by the service.

Patients on the inpatient ward were discharged by the RMO on duty in accordance with the relevant consultant's recommendations. On the day ward, discharge was nurse lead, although nurses could contact the RMO or relevant consultant prior to discharging a patient if a second opinion was necessary.

There was only one unplanned return to theatre between October 2017 and Septemer 2018.

Following discharge, patients could access a 24 hour advice line, should they have any ongoing concerns.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

There was an up-to-date complaints policy. Formal complaints were acknowledged within three days of receipt and were fully investigated and responded to within 20 working days. If the timescale could not be met, the patient would be contacted via their preferred method of communication and provided with a reason for the delay.

Good

Surgery

The hospital director reviewed the root causes identified and agreed the final letter. The senior leadership team and staff told us that learning from complaints was shared with all staff at quality and governance meetings.

Senior staff told us that they took complaints and patients' concerns seriously and saw them as learning opportunities.

Information on how to complain or raise a concern was readily available throughout the service.

The centre received 45 complaints overall between November 2017 and October 2018 of which, one complaint was referred to the ombudsman. All complaints had been appropriately reviewed and responded to in line with the policy.

Are surgery services well-led?

Good

Our rating of well-led improved.We rated it as **good.**

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The leadership for the service was the responsibility of the hospital director. The medical director for the service managed the different surgical pathways, and retained overall managerial responsibility for medical staff within these pathways, whilst the head of nursing was responsible for the overall governance of the service and for the inpatient and day surgery wards. The head of nursing also had managerial responsibility for the nursing staff.

The majority of staff we spoke with spoke highly of the leadership of the service, whom they described as supportive and visible. However, some expressed concern at the slow rate of change within the service and said that they did not always feel that their concerns were listened to. All staff spoke highly of the local leadership within each of the service areas, for example on the wards or in theatres and said that their managers frequently advocated to the senior leadership on their behalf.

The service was committed to implementing the Workforce Race Equality Standard (WRES), a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

At our inspection in April 2017, a significant portion of staff we spoke with stated they had experienced or seen instances of bullying and harassment of staff while working with the service, particularly towards Black and Minority Ethnic (BME) staff. Staff told us that the situation had and was continuing to improve. Senior staff told us there had been significant efforts to address these concerns. The provider had a Health Care Equality, Diversity, and Inclusion Steering Group which produced an annual report. We had sight of the report for 2018 which set out progress against pre-determined objectives to improve equality and diversity across the organisation. The steering group met on a monthly basis with staff drwn from across the provider's locations.

In addition, there was a robust equality and diversity action plan in place which we had sight of, which detailed key objectives and timelines for achieving those objectives.

The medical director told us that he had personally spoken to a number of medical staff about their conduct. This was reflected by staff, who told us that there had been improvements in the issues around bullying and harassment. In addition, since the last inspection, the service had updated its whistleblowing and raising concerns policy.

We were told that in theatres there was a non-hierarchical structure, with staff feeling confident to challenge more senior staff regarding concerns they might have. In large part this was associated with the increased emphasis on the World Health Organisation (WHO) checklist. An example of this was an incident of a surgeon who intended to carry out an operation on a patient without appropriate consent, until challenged by a healthcare assistant (HCA), with the HCA being supported by the medical director.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

Good

Surgery

The service's vision was to be the number one partner to the NHS for elective surgery. All of the staff we spoke with were aware of the vision and said that they felt enabled to contribute to it.

At the time of our inspection, the service was continuing to implement its 2018 strategy to achieve that vision. This included stated aims of improving and maintaining clinical quality and patient experience and recruiting and retaining high quality staff.

The provider had a set of core values which were displayed throughout the service. Staff we spoke with were aware of the values and said that they shared them.

Culture

Managers across the service endeavoured to promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Overall, there was a positive culture within the service. Staff told us that they enjoyed their work and felt that they were usually supported to provide the best possible care to patients. Theatre staff described a positive working culture within theatres. They said that there had been noticeable improvements in the culture in theatres since the appointment of the current theatre manager in late 2018.

We spoke with a trainee paramedic who was undertaking anaesthetic training within the service, who spoke highly of the culture in the service and said that staff had made them feel welcome and taken time to explain their roles and what they were doing.

A number of staff described significant concerns regarding the culture and interaction between the recovery team and other teams. This was also recognised by the senior leadership team, who said that they were aware of the issues and were working to address them. We were told that the issues were longstanding and related primarily to communication issues. Following a meeting between the heads of department an action plan had been agreed to improve the relationship between the services. The action plan had agreed actions with agreed dates for review and named staff responsible for ensuring their progress.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

There were monthly quality and governance assurance meetings, attended by the senior leadership team and the clinical leads. There was a standing agenda for these meetings, which included a review of all reported incidents. In addition, staff from across the service were welcome to attend. The governance lead told us that staff frequently attended to raise concerns with the senior leadership team.

The service outsourced several services and the senior leadership team told us service level agreements (SLAs) were reviewed nationally at Care UK, not just locally. The head of nursing had developed an operational policy to ensure pathways were mapped as to how the service understood them which helped the service monitor the SLAs.

The senior leadership team told us that quality and governance was a focus for all staff. The centre suspended clinical activity bi-monthly for quality and governance meetings and all staff were invited to attend. Staff told us consultants also attended as part of a multidisciplinary team as they were directly employed. The meetings were well attended and took place over a full day with half the day dedicated to governance followed by a departmental team meeting for the rest of the day. The leadership team were always present at the quality and governance meetings as they felt it was important for staff to get key messages from the triumvirate. Staff told us they felt comfortable raising concerns at the QGA meetings.

There was also a regular heads of department meeting. We had sight of the minutes of the October 2018 meeting at which it was determined to hold the meeting at monthly intervals. Each of the heads of department provided an update, following which their colleagues suggested actions to address risks or concerns. Following the meeting of October 2018, this was expanded to include peer supervision between the heads of department to drive improvement across the service as whole.

The governance structure of the service fed into the governance structure of the provider as a whole, meaning that best practice and learning from incidents could be shared effectively across the services.

Managing risks, issues and performance

Good

Surgery

The service had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

We had sight of the service-wide risk register. We were informed that there was no specific risk register for surgery. However, there was a specific risk register for theatres and for the day unit. In addition, surgical risks were included on the service-wide risk register. The governance lead told us that the risk register was discussed at the monthly quality and governance assurance meeting. They said that at the meeting, the senior leadership team assessed each of the concerns reported by staff through the electronic reporting system for consideration for inclusion on the risk register. In addition, the governance lead was responsible for presenting the risk register to the provider's overall risk manager on a monthly basis.

The service ensured effective service provision via a monthly internal and provider-wide audit programme. We had sight of action plans arising out of audits. The quality and governance manager led on audits. The service had a monthly audit programme which was displayed in clinical areas in the form of an audit calendar. The provider also had a national health and safety manager who was responsible for business continuity. The service completed risk assessments and prioritised the services using RAG ratings, where red meant absolute necessary. The senior leadership team told us the service had a major incident plan which senior leaders reviewed regularly. Staff provided an example of how the service had dealt with a major incident which involved ensuring the safety of staff and patients in the building further to a police incident in the area. Senior leads kept staff and patients informed of the actions taken by the service.

The service used an electronic tool to review clinic utilisation, bookings and theatre utilisation. The patient services team received daily reports from the data analyst which showed the number of appointments, triages and outcomes outstanding.

The service had a weekly meeting to review the operational metrics. Attendance included the hospital director, deputy hospital director, head of nursing, patient services manager and data analyst. The finance manager also attended on some occasions. The weekly operational report was presented in patient groups at different points of the patient pathway. The data was split by speciality. The service used this as an opportunity to review their currently SLAs with providers as well. For example, having noticed the long waiters due to diagnostics, the service secured three additional SLAs with external providers to provide a diagnostic service.

A number of risks on the risk register at the time of our inspection were speculative rather than specific to the service, for example one risk related to an increase in risk as a result of staff not following procedures. The governance lead said that the provider recognised that the risks included on the register were of a generic nature and needed to be more service specific. The governance lead told us that the service was currently working to encourage clinical leads to escalate specific concerns within their area.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff had access to policies and procedures through the intranet although some staff reported that the system was often slow.

There were computers available for staff use on both wards. Access to computers was more limited in the theatre suite with just three bank computers. The service had access to the information technology corporate support team 24 hours a day. Staff told us the information technology (IT) systems were generally reliable, although some staff have had some user issues. The centre shared the local trust IT connectivity which meant the consultants could access the local trust's system to access pathology and radiology results easily.

Information relating to topics such as training opportunities or learning from incidents was shared in the theatre suite via a large notice board in the staff breakout room.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Two of the consultants had undertaken training in the impact of human factors on patient safety, in addition they had undertaken 'train the trainer' courses and were cascading the human factors training to all staff across all

specialities in the service. Staff who had undertaken the training told us that it was interesting, relevant and inspiring. One of the ward clerks told us that the course had given clinical staff an appreciation of the importance and impact of the clerical role.

There was a monthly staff forum where staff could learn about new developments and share concerns as well as best practice. We had sight of the minutes for the staff forum for November 2018. At our inspection in April 2017, we noted that attendance at the staff forum was poor. Whilst there was a diversity of representation at the forum in terms of staff role.

The service participated in the provider-wide 'over to you survey' where staff were asked to provide their views on working for the provider. The survey was not split between specialities and was, therefore, location wide. The highest scoring positive answers were to the questions were 'I know who the senior managers in my area or business unit are' and 'I know how to raise a concern at work', the lowest scoring negative responses were to the questions 'considering what my job is, I am satisfied with my level of pay and benefits' and 'have you experienced harassment, bullying, or abuse from colleagues in the last 12 months'. However, whilst the question regarding bullying and harassment was one of the lowest scoring negative responses, staff reported a significant improvement in respect of instances of bullying and harassment since the April 2017 inspection.

We had sight of the 2018 action plan for theatres arising out of the most recent 'over to you' survey. One of the actions listed was to establish a theatre users' group. At the time of our inspection the theatre users' group was established and staff spoke highly of it.

There was a provider-wide staff awards system, whereby staff could nominate colleagues for a number of awards, which would then be presented at an awards ceremony. A number of staff we spoke with said that the awards were meaningful and meant a lot to them. There were posters throughout staff areas advertising the staff awards.

At the time of our inspection, the theatre manager had recently started a theatre-users' group. This gave theatre staff an opportunity to discuss issues in theatres and to share best practice. The group was well attended and staff told us that it was useful opportunity to meet with colleagues and to make real changes in the way the theatres were run.

Patients were involved in carrying out hand hygiene audits, where they were asked to record various observations regarding staff's adherence to hand hygiene protocols for each staff member they interacted with over a given period of time. We had sight of the patient led hand hygiene audit for June 2018.

The service had a patient forum which met twice a year. Patients were made aware of the opportunity for them to join or contribute to the patients forum via the welcome packs provided to them on their admission.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

At the time of our inspection, the service had recently started undertaking hip replacement surgery with the patients being released on the same day. Patients suitable for this pathway were identified during their pre-surgery consultations and pre-assessment.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

Our rating of safe stayed the same. We rated it as **good**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The provider had replaced the term "Statutory and Mandatory" with the term key skill sets which was compulsory for all permanent and temporary staff including bank staff. A "key skill set" was the minimum set of training required based on legal and legislative requirements and was divided into seven categories. These included health, safety and environment; information governance and data protection; safeguarding of adults and children; clinical governance; resuscitation; medication and equality, diversity and human rights. The compliance target rate was 95%.

Data provided by the service showed the overall staff compliance rates were: basic life support (BLS) e-learning (96.55%), BLS (88.68%), immediate life support (88.06%), advanced life support (ALS) 100%, Health and Safety Executive (HSE) for employees (94.9%), fire awareness and safety (69.20%), moving/lifting patients (94.4%), moving/lifting patients practical (79.84%), chaperone (97.06%), infection prevention and control (IPC) e-learning (91.24%), IPC practical (97.67%), clinical governance (91.95%), equality and diversity (87.74%) and information governance (89.67%). During our inspection, the lead nurse told us the compliance for fire awareness and safety was now 100% for outpatient (OPD) staff.

Staff told us the training was mostly delivered via e-learning and some modules such as ILS, BLS and moving and handling were face to face. Managers and staff told us they received protected time to complete the e-learning. The lead nurse told us that some staff found it easier to do the training at home in which case, staff would get the time back or get paid overtime. Staff told us they received reminders when a module was due for renewal.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The provider had corporate safeguarding policies and procedures in place to keep vulnerable children and adults safe from harm and abuse. The service had local standard operating procedures (SOPs) which reflected the corporate safeguarding policy and included local referral forms and local contact numbers.

The head of nursing and the ward manager were the safeguarding leads for the centre and had both completed level four safeguarding training. The safeguarding leads provided face to face staff training as part of the mandatory training programme. The safeguarding leads had completed the Workshop to Raise Awareness of Prevent(WRAP) training which is designed to help make staff aware about their contribution in preventing vulnerable people being exploited for extremist or terrorist purposes.

The service incorporated information about female genital mutilation (FGM) in their procedures. All the staff members we spoke with were able to identify abuse and demonstrated consistent awareness of FGM.

Although all staff we spoke with were aware of the safeguarding leads, staff awareness of how to raise a safeguarding referral was inconsistent. Staff told us if they had to make referral, as they do not make them often, they would seek support from the lead nurse or safeguarding leads. The nurse station in OPD had a copy of the safeguarding referral flowchart and staff told us that refresher training was available if required.

Data provided by the service showed the overall staff compliance rates for all departments were Prevent training (96.82%), Safeguarding Children level one (92.86%), Safeguarding Adults level one (96.15%) and Safeguarding Adults level two (96.9%).

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The centre participated in the national Patient-Led Assessment of the Care Environment (PLACE). The service provided the May 2018 results which showed the service scored approximately 99.5% for cleanliness (against the national average 98.5%).

All areas we inspected were visibly clean, safe and compliant with Health Building Note (HBN) 00/09: infection control in the built environment. The centre outsourced their cleaning services to an external provider. The external contractor had weekly cleaning schedules for each room which logged the tasks the contractor should complete, the days completed and a signature. Staff told us that housekeeping would also visit daily to clean the OPD areas. The OPD department had a weekly cleaning schedule for the assessment rooms which the OPD staff completed. The cleaning schedule included furniture, and equipment. During the inspection, we found the cleaning schedules had been completed fully in each assessment room.

We observed OPD staff wiping down beds, chairs and equipment before and after use. Clean equipment was identified by dated 'I am clean labels' so that staff were clear when it was ready for use. For example, we saw 'I am clean labels' on weighing scales.

Each clinic room had disposable curtains used for privacy and dignity. However, we found replacement dates were not noted on all the curtains in the OPD clinic rooms. Staff told us that although the policy states they should be replaced every year, housekeeping staff replaced them every six months. During the inspection we found the curtains in rooms two and eight did not have a date which meant it was difficult to determine when they had been last changed. Room seven's curtains had December 2017 which was not in line with the service's policy. We raised this with the nursing staff who immediately alerted housekeeping staff and told us they would log this as an incident. Housekeeping staff told us they had an issue with some of the curtain rails and had raised this.

We observed staff wearing personal protective equipment (PPE), including aprons and gloves, when delivering personal care. Patients, relatives, staff and managers we spoke with consistently told us they were satisfied with the cleaning services in the outpatient areas.

During our last inspection, we found some of the consultants challenged the 'bare below the elbows' policy and refused to comply. However on this inspection, we found this had improved as we observed all staff groups including consultants were bare below the elbow and actively washed and sanitised their hands before and after contact with patients in line with the National Institute of Clinical Excellence (NICE) Quality Statement 61 (Statement 3). Hand washing facilities and PPE were readily available and clearly signposted in all the areas we visited including the day unit where endoscopy patients were admitted. We saw sanitising hand gel in wall mounted dispensers for staff and visitors to use in all of the areas we inspected. We also saw hand gels on door handles to day unit and endoscopy suite.

There were safe arrangements for the handling, storage and disposal of clinical waste, including sharps bins in accordance with Health Technical Memorandum (HTM) 07/01: The Safe Management of Healthcare Waste 2013. We found the sharps bin was correctly assembled, labelled and not overfilled but on occasions found the

temporary closure was not always used. However, we did not see any evidence of adhering to the EU legislation of safe needle free system in place (EU Directive 2010/32/EU), where every healthcare setting must be moving towards safer sharps system.

In endoscopy, we found the sink was clean, uncluttered and compliant with HBN 00/10 with a poster on handwashing technique displayed. The endoscopy service used a mixture of hazardous (orange) and black household waste bins. These bins were not overfilled and were labelled clearly. We visited the endoscopy decontamination suite and found good processes in place for cleaning with a water disinfectant. The decontamination machines were WiFi operated and sent messages to the manufacturers hub. The service had an external provider who completed the water and enzyme testing.

All of the scopes we looked at were compliant with the Health Technical Memorandum (HTM) 01/06: the management and decontamination of flexible endoscopes DH (2016) and HTM 01/01: decontamination of surgical instruments. We followed the scope process through the decontamination suite and found processes were followed well. We saw two washer disinfectors the service had recently installed in December 2018. Staff told us the provider was in the process of reviewing the corporate endoscopy procedures to reflect the new machines. Although staff told us there were some initial problems with the machines, at the time of our inspection, we found the machines were running efficiently. The endoscopy team told us the new equipment had made a big improvement and had cut down the cleaning time by 20 minutes.

The centre achieved 100% against all standards for the June 2018 Infection Prevention and Control Patient (IPC) Audit which involved 12 patients. The standards included observations on staff being bare below elbows, staff members washing their hands, staff members using alcohol gel before and after any examination/procedure, staff members using personal protective equipment (PPE), staff using alcohol gel or washing hands after removing PPE and if the patient was satisfied with the infection control measures taken.

The service completed monthly hand hygiene observation audits in the department monthly which involved observing the IPC compliance for five staff members. The service results for December 2018 and January 2019 showed the service achieved 100% and 96% respectively. The department also completed monthly IPC audits which looked at hand hygiene, cleaning, assessment of care, environment and equipment. The service provide the IPC audit for November 2018 which showed the department achieved 90%.

The service had a corporate policy for Infection Prevention and Control policy for Carbapenamase producing Enterobacteriaceae (CPE) which was in date. CPE screening is required if a patient is admitted from another hospital or abroad in line with guidance from NHS England and Public Health England (2013). The service had a comprehensive policy which included the screening protocol, how to manage a positive screen, minimising risk of CPE spreading and a patient information card if they are a carrier of CPE. Although most of the staff we spoke with demonstrated awareness of CPE screening, some staff understanding of processes was inconsistent.

Between October 2017 and September 2018, the centre reported zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) and Escherichia coli (E-Coli) bacteraemia.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

In April 2018, the outpatients and administration department relocated from Barley Court to the main treatment centre site. However some functions such as medical records and the bookings team were relocated to the sister treatment centre in Gillingham. Service leaders told us the reconfiguration had addressed two concerns highlighted in the previous inspection: the risk regarding the transportation of patient files to and from Barley Court, and the staff concerns around the procedures for managing difficulties at Barley Court in absence of a resuscitation team.

The outpatient waiting area was situated adjacent to the nursing station which was always manned by a shift

leader in the nursing team. Staff told us the new outpatient space was tight especially during busy periods. We observed the challenges with limited space during the inspection.

Systems were in place to ensure the environment was safe with secure access to theatres and other clinical areas. Access to the first floor was via an electronic pass. During the inspection, staff members checked our identification when we needed access. Staff told us there was a staff room on the first floor with the main kitchen.

The centre displayed information for visitors near the entrance which included the previous CQC inspection ratings and a notice board with photographs of the senior leadership team, consultants and heads of departments.

The centre had eight OPD clinic rooms of which two rooms were for nurse led preassessments and one room for blood tests. The waiting area had approximately 30 chairs which were clean and fully wipeable. The flooring of the waiting area and the clinic rooms were clean and dust free.

There was safe provision of emergency equipment with accessible resuscitation trolleys and equipment used for the management of difficult airways. The centre had two resuscitation trolleys, one in theatres and another on the day unit. OPD staff told us they could use the resuscitation trolley on the day unit, if necessary. Nursing staff in the day unit and theatres completed the checks on the resuscitation trollies and removed any expired medicines, which the pharmacy team then replaced for them.

The service had a dedicated theatre for endoscopy with an adjoining decontamination suite. In endoscopy, we found a clean and tidy environment in all patient areas we visited demonstrating full compliance to Health Building Note (HBN) 00/10 Part A (flooring) and HBN 00/09 in the built environment. All flooring was clean and in good condition. In the endoscopy suite, there was piped oxygen and suction equipment with alarm call bells in each bed space and recovery area. Facilities included a clean and uncluttered disabled toilet.

There was a private administration room which had a good selection of patient information leaflets and could be used to talk with patients in privacy. Storage space for equipment was limited in the endoscopy and was included as a risk on the risk register. However, senior leads had an action plan to address this and had ordered new cupboards.

During our last inspection, we found there was no scope guide available for colonoscopy and no paediatric scope for use with narrow structures such as diverticular disease. On this inspection, we found the service had addressed this with sufficient scope guides and small scopes available.

The service outsourced equipment maintenance and repair. Equipment in the clinical areas we inspected had evidence of up to date safety testing with visible stickers. For example, in the OPD clinic rooms, we checked three pieces of equipment (ECG machine and two blood pressure machines) and found in date safety testing stickers displayed on all items.

The centre's infrastructure and equipment was replaced, renewed and refurbished on a rolling basis. For example, in the last year, the service had replaced the endoscopy scopes and stack systems and were currently replacing the endoscopy washers. Staff told us consultants did not bring or use their own equipment.

The trust provided the equipment maintenance log as evidence and we found that for each item of equipment, there was a last repair dates where applicable, last planned preventive maintenance (PPM) date, any missed PPM and the next PPM date.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

The service's referral criteria automatically excluded a large number of risk. Patients did not meet the referral criteria if: they had a body mass index of greater than 42 (for general/regional anaesthesia) or greater than 45 (for local anaesthesia), were under 18, were pregnant, required complex surgery or prolonged inpatient rehabilitation or had a chronic disease that would require immediate post-operative care in an ITU such as sleep apnoea or uncontrolled cardiorespiratory disease, had poorly controlled co-morbidities, had sickle cell anaemia, complex clotting disorders or significant renal failure, suffered a myocardial infarct, had undergone coronary

artery bypass surgery or coronary stenting in the last six months (12 months for drug eluting stents) or if they had suspected cancers. Patients with a BMI between 40 and 42 would be assessed by a consultant anaesthetist who would decide about their suitability to be treated safely.

Two dedicated nurses triaged all the referrals received through the NHS e-referral service (e-RS) by going through the referral criteria. For example, the triage team checked average blood sugar levels (HbA1c) for patients on the local trust's system to see if the criteria was met or highlighted if the test needed to be done before preassessment. Staff contacted patients who did not meet the criteria and provided an explanation. Staff also contacted the patient's GP via telephone and letter to update them.

We spoke to the triage team who told us the clinical information summaries were printed off site and delivered to the centre once a day (1pm). Any queries would be discussed with the consultant. Staff told us that if a patient was diagnosed with cancer through the pathway, the patient was immediately referred onto the two week cancer pathway at the local NHS trust. Where patients had any suspected cancers, the triage team would speak to the GP and consultant before sending the patient over to the local NHS trust. The triage team told us that sometimes the information in the referral was not completed fully. The forms did not include allergies but included information on needs for patients living with dementia and learning disability. Staff told us frailty and the need to have an interpreter was picked up within the GPs notes.

Once the patient has been clinically triaged and accepted, a Care UK medical record would then be created. Patients received their appointment at the time the referral was made. However, as some appointments could be booked 48 hours before, there was a possibility that those referrals may not be triaged by the triage team.

Although staff told us the system worked well with very few referral queries getting to the consultant, staff told us their time could be better utilised if they were able to print the clinical information on site themselves and not be reliant on the daily delivery. Staff told us that activity levels had increased and despite medical records now being off site, there had been no incidents where the patient was seen and the records were not available.

The senior leadership team told us they wanted to pilot an administration triage as the service had rigid exclusion criteria in place for administration staff to follow. This was currently in discussion. This would involve the administration team screening the referrals against the exclusion criteria and any red flags would receive a review from the nurses and consultants. Although staff told us the criteria was checked at preassessment appointments, the senior leadership team wanted to eliminate appointments taking place without triage happening first.

The service subcontracted their resuscitation team from the adjacent NHS trust hospital. Service leads felt it was important there was an on site presence and so the resuscitation team was identified each morning. The service had an allocated anaesthetist who was the resuscitation lead for the day and was available for emergency situations and management of deteriorating patients. Staff told us they had access to resuscitation trolleys situated in theatres and the resuscitation team in the adjacent NHS trust hospital were available and responsive. Staff told us that all registered general nurses (RGNs), selected nurses and HCAs were ILS trained. There were ALS trained members of staff in theatres at all times. All staff including reception staff completed BLS.

In all of the records we reviewed, each patient received a comprehensive individual risk assessment during their nurse-led pre-assessment which included venous thromboembolism (VTE), falls assessment and nutritional assessment. During all the consultations we observed, staff took comprehensive patient histories including allergies and medications taken by the patient.

Staff told us that if an unwell patient called in, the anaesthetist or resident medical officer (RMO) would complete a telephone consultation and make the clinical decision if the procedure should go ahead or not. The decision would be emailed to the bookings team and would include advice on when the patient could be rebooked for the procedure or if any additional appointments were needed beforehand. The medical team would email the patient pathway coordinators and patients services manager so all the relevant staff members are informed.

In the endoscopy suite, staff took the appropriate safety checks before, during, and after surgery by completing World Health Organisation (WHO) checklists. It was recommended by the National Patient Safety Agency in

2010 that the WHO surgical safety checklist should be used for every patient undergoing a surgical procedure. We saw that additional risks for all patients undergoing a surgical procedure were assessed and responded to by applying the WHO surgical safety checklist in the operating theatre environment. The purpose of the checklist was to check and approve all safety elements of a patient's operation before proceeding. The WHO checklist involved checking allergies and discussing any concerns and obtaining consent. Patients with allergies were distinguished using wrist bands with full documentation in the patients notes. We saw evidence of the WHO checklist being completed fully in all seven of the patients notes reviewed. The centre reported a score of 100% in October 2018 for the audit of process and documentation of the WHO checklist.

Endoscopy patients arrived at reception on the day of the procedure and were taken into the endoscopy suite in the day unit. Patients would be admitted by the nurse and seen by the surgeon where consent and sedation would be discussed. Staff told us a registered nurse accompanied the patient to theatre.

The service provided patients with comprehensive discharge information, a 24 hour advice line for post discharge concerns and a post discharge follow up phone call for all patients at 24 to 72 hours.

Nurse staffing

The lead nurse managed the OPD service. The outpatient model was based on the staffing required by scheduled outpatient clinic as well as outpatient activities and treatments. Staff told us there was always a shift leader on each shift. The service planned staff allocations on a rolling four week period and factored in chaperones for each consultant and any booked annual leave. Shifts were staggered with two shifts in the day: 08.00 to 18.00 and 11.00 to 21.00. During our inspection, we saw the OPD allocation for both the morning and afternoon shifts displayed near the nursing station.

The service calculated core staffing requirements within all departments in accordance to budgeted workload. The nursing staff worked across the departments including OPD, inpatients and the satellite clinic in Ilford. Patients who may possibly require extra care were identified at pre assessment and were provided with one to one care on the day of surgery if necessary.

The OPD service used bank regularly each week as well as overtime for existing staff. Although the service did not use agency staff, staff told us they were able to if needed. The bank staff were regular staff who worked set days on Wednesdays and Saturdays, which provided continuity for the OPD service both for patients and staff.

Data provided as part of the provider information request stated the OPD department consisted of 9.0 FTE nursing staff and 6.9 operating department practitioner (ODP) and health care assistants (HCA). Between November 2016 and October 2017 the nursing staff and health care assistant (HCA) turnover was 11% and 14% respectively. The service provided data for November 2017 to October 2018 which showed the HCA turnover had improved to 0% but nursing staff turnover remained unchanged at 11%. We asked the lead nurse about this who said they didn't agree with the data and said the figure was incorrect.

During our inspection, staff told us that two nursing staff had left. We requested up to date OPD staffing data and the service provided data to show the whole time equivalent (WTE) nurse staffing levels for January 2019. The department had one department manager, 2.5 team leaders, 7.8 staff nurses, 5.55 HCAs and four bank staff nurses. Bank nursing staff had worked seven shifts in January 2019 which worked out to 3.92% of qualified hours being covered by bank staff. The service had advertised for two staff nurses and appointed four HCAs who were due to start in the coming weeks. Staff told us that the human resources (HR) support had improved and was more responsive which meant there was reduced delay in getting new staff to start. Although the overall OPD service reported a sickness rate of 1.127%, the sickness rate for HCAs was 5.32% against the expected sickness rate of 2%.

Staff also told us there were vacancies in the reception team. Previously, the service had three reception staff but the service had relied on one staff member since October 2018. Staff told us that either a nurse or HCA would cover the reception during lunch breaks.

Medical staffing

Medical staff were employed, self-employed contracted, permanent staff or on bank contracts. The service did not operate a practising privileges model. The senior leadership team told us that most of their consultants

were self-employed practitioners. The service always had one RMO on call. Nursing staff told us it was easy to access medical staff as they had their contact details as well as the RMO details. Although each consultant was responsible for their patient 24 hours per day, staff told us that patients could be assessed by one consultant and operated by another.

The senior leadership team told us that the RMOs were provided by an outsourced company and the medical director was responsible for approving all the medical staff who came to work at the centre.

The endoscopy team included one employed endoscopist, one agency endoscopist, five registered nurses, a decontamination lead and five HCAs. Interviews had been scheduled for a further three registered nurses which would take the endoscopy team to full staff establishment.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Following the reconfiguration of the OPD service, medical records were stored off site at the sister treatment centre in Gillingham. The senior leadership team told us the reconfiguration highlighted that internal processes for booking the records in and out required embedding. Although staff told us no patients records had been lost, they did say records did get mislaid on occasions before being located. The centre mitigated this risk by using a web based programme to track the location of the records at all times. The centre also had a dedicated person who checked the notes ahead of the clinic to ensure the notes were complete and included any recent test results. Staff told us these checks were done one week in advance which allowed enough time to get any missing information if identified. The records were available in clinic on the day of the patient's appointment and tracked to the appropriate clinic using a web-based programme.

The service had corporate policies for clinical written documentation, records retention schedule and archiving policy and patients records image storage policy. The service archived all medical records six months following the patient's last episode of care and records could be tracked and an excel spread sheet was also completed to ensure a second check was completed prior to the notes leaving the site. The records were then placed in medical archiving boxes, sealed and collected via arrangement with the service's archiving provider which was accredited to provide these services. If the patient returned for any reason, the centre could request the records from archiving to be securely returned. The records were securely transported in medical notes boxes and delivered in the service's own transport with their employed driver. Data provided by the centre showed that between August 2018 and October 2018, 100% patients were seen in their outpatient appointments with all their relevant medical records being available.

The medical records were predominantly paper based and were stored in locked cupboards when on site. Within the OPD clinic rooms, we observed all notes were stored securely in a trolley and shut during consultations. We observed consultants making electronic notes on the system as well as printing a hardcopy for the patients file. During clinic hours, the nursing station had a locked filing cabinet which stored patient records needed for clinics running on each day. The station was manned by a member of the nursing team, mainly the shift leader. Staff told us clinical summaries were sent to GPs electronically whilst patients received a hard copy letter.

We reviewed seven patient records and found all had been completed. We observed tracking and traceability status on all patients undergoing endoscopy. In all of the records reviewed, the following had been completed: VTE risk assessments, patients observations, consent forms, nutritional status, WHO checklist, diagnosis and management plan documented, name and grade of doctor/nurse reviewing patient clearly noted and all notes were signed and dated. During our observation of a clinic, we saw that a patients notes contained an allergy sticker.

Medicines

There was minimal pharmacy input required in outpatients. Within the OPD department, there was only one medicines cupboard in clinic room two. The cupboard was locked and the keys were kept securely behind reception. The OPD department kept minimal medicines and no controlled drugs. Examples of medicines included corticosteroid injections, local anaesthetics and eye drops. In room four, we saw an anaphylaxis box and a blood spillage kit which were in

date. Nursing staff checked the stock weekly for their expiry dates and placed any orders using prescription slips where stock was low. The OPD service did not report any medicines incidents.

The ophthalmology clinic room (room 3) was the only clinic room to have a fridge to store eye drops. Staff showed consistent awareness of what to do if the fridge was out of range and showed us the flowchart in the log. Although staff told us the log should be completed daily, we found several omissions. For example, from December 1 to 16, the fridge log had no fridge readings. We raised this with nursing staff who could not explain the omissions but told us they would log this as an incident. We also raised this with the pharmacy manager who told us the pharmacy team carried out an audit which looked at the completion of the fridge log. We were told the recent audit did not include the fridge in OPD as the pharmacy team were not aware there were any eye drops in the fridge. The pharmacy manager told us this would be addressed going forward.

During the inspection, we found the hardcopy of the latest British National Formulary (BNF) September 18 to March 2019 was available at the nurses station.

The centre was not using e-prescribing and used the corporate prescriptions which could only be dispensed at the on-site pharmacy. The pharmacy team obtained the prescriptions in batches and the originals stayed in the pharmacy. The duplicate copies went to clinic and were only given to consultants when needed. The service had a safe process in place to store and track the prescriptions. For example, the pharmacy team dispensed against the duplicate copies and had a system to track all dispensed medicines. The patient received a copy should they need any further supplies from their GP. Staff told us that patients were supplied with sufficient medicines for the weekend and the patients could return on Monday to collect the remaining supply, if needed.

The service also had prescriptions that could be dispensed off site (FP10s). Staff told us they were only used for items the pharmacy did not stock. During the inspection we saw the FP10s were stored securely and were only given to consultants when required. The service had a process for validation and checking of FP10s.

The pharmacy team used an electronic software to complete audits on electronic devices. The department took part in the overall medicines management audit in the centre. The medicines management audit results for November 2018 showed the service achieved 95% in responsibilities and prescribing an stock control; 96% in controlled drugs and 94% in administration, errors, incidents and recalls.

Staff told us the OPD service did not have any patient group directions (PGDs) as the clinics were consultant led. PGDs allow some registered health professionals (such as nurses) to give specified medicines to a predefined group of patients without them having to see a doctor. However, in endoscopy, PGDs were used only for bowel preparation. The lead nurse for endoscopy had the responsibility to ensure the relevant staff members had read and understood the PGD and signed appropriately.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff reported incidents through an online electronic reporting system which alerted the outpatients manager that an incident had occurred. Staff we spoke with understood their responsibilities for reporting incidents and were confident in using the system.

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. Between November 2017 and October 2018, the service did not report any Never Events or serious incidents within the outpatients department. The service provided the OPD incident log for 2018 and we found each incident had been appropriately documented with named leads, risk grade, lessons learnt and actions taken.

The outpatient manager investigated the incidents that occurred within the department. Staff were made aware of the outcome of incidents and learning was shared

through the monthly quality governance and assurance (QGA) meetings and team meetings. Heads of departments discussed incidents during their meetings and cascaded information down to staff.

During the inspection, we saw data displayed for December 2018 which showed there had been 15 incidents in total throughout the service. From these, two incidents were for OPD. One incident involved a patient who attended surgery but had not been pre-assessed and the second incident was regarding a patient whose x-ray results had not been reviewed in clinic and the results raised the query of suspected cancer. The service reported the second incident as a serious incident. We requested an update regarding the investigation for the serious incident. Although the investigation process was ongoing, the service provided an overview which showed that the initial investigations were comprehensive with a timeline of events and a list of the care delivery problems identified.

All staff in both outpatients and endoscopy had received training and could report incidents. Although staff we spoke with told us that clinical incidents were very rare, staff were aware of the reporting structure. In endoscopy, all staff members completed incident reports and informed their manager. During the inspection, we were provided with a copy of the adverse outcome incidents and no-adverse outcome incidents for October 2018 in endoscopy. We found appropriate actions had been taken including the application of duty of candour.

The duty of candour (DoC) is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients or other relevant persons of 'certain notifiable incidents' and provide reasonable support to that person.

The compliance rate for all staff in Duty of Candour (DoC) training was 95.4% against the target of 95%. Although staff we spoke with showed consistent knowledge on the subject, staff told us that it rarely had to be used in outpatients because of the relatively low incident rate.

Staff gave us examples of incidents and lessons learned and actions taken. For example, staff told about an incident where one patient's family member who had a pacemaker which stopped working in the waiting area. Staff told us the situation was managed well by the anaesthetist with a debrief session after with staff to share learning.

Safety Thermometer (or equivalent)

The head of nursing told us they had developed safety stations three years ago which were staff facing areas for each department. The safety station would display important information such as complaints, theme of complaints for the relevant area, incidents and Commissioning for Quality and Innovation (CQUIN) performance.

During our inspection, we did not see a safety station in OPD. Staff told us the OPD department was waiting for a notice board which was on order. However, staff told us they were kept informed of incidents and complaints in their departmental meetings and QGA meetings.

The service completed monthly audits to check if VTE assessments had been completed. The service provided the VTE CQUIN report for July 2018 to December 2018 which showed the service exceeded the 95% target achieving 99% for each month, with the exception of September 2018, which was 96%.

Are outpatients services effective?

We do not currently rate effective in outpatients services. However, we found:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The service had a system in place for reviewing and disseminating alerts and guidance that were appropriate to the care delivery within the centre. The central policy team for the provider advised the centre of any new published or researched guidance that related to good practice, including National Institute for Health and Care Excellence (NICE) guidelines. New ratified guidance would be disseminated to managers for review and implementation. Staff were also encouraged to review new evidence based guidance.

The heads of departments advised staff of any changes. Alerts and guidance were discussed as a standing agenda item at the Quality Governance and Assurance (QGA) meetings. Staff gave us the recent example of the new venous thromboembolism (VTE) guidance. We reviewed the QGA meeting minutes for October 2018 and found staff received communication regarding the new VTE guidance and when the amended corporate policy would be available.

Nurses in the outpatients department told us they followed national and local guidelines to ensure safe and effective patient care. There were several assessments that followed published best practice. They included falls assessments, knee and hip assessment scores and malnutrition universal screening tool (MUST).

We saw examples of evidence based guidance on the staff intranet. For example, the corporate Infection Prevention and Control policy for Staphylococcus aureus (including MSSA, MRSA and screening) referred to guidance from the Department of Health (2007) and NICE Clinical Guidelines (2012) on Infection control: Prevention of healthcare associated infection in primary and community care. We observed that each policy had a reference number, title, description, expiry date, author and date last updated.

During our last inspection, the centre was not undertaking audits in the outpatient department (OPD) to measure performance against the guidelines. On this inspection, we found this had improved as health and safety audits, VTE audits, IPC audits and audit of waiting times were completed in the OPD areas. The department also participated in overall centre audits such as the documentation audit, medicines management audit and PLACE audit.

The Joint Advisory Group on Gastrointestinal Endoscopy (JAG), established under the auspices of the Academy of Medical Royal Colleges, sets standards for individual endoscopist's training, quality assurance of endoscopy units and quality assurance of endoscopy training. The centre had successfully renewed their JAG accreditation in June 2018.

The hospital was taking part in the Commissioning for Quality and Innovation (CQUIN) project by collecting data regarding smoking cessation. The aim of the CQUIN framework is to support improvements in the quality of services and the creation of new, improved patterns of care. The outpatients department collected data for patients undergoing a procedure indicating smoking status and quantity, if staff offered advice around cessation and whether a referral to a cessation programme were made.

Nutrition and hydration

Each patient received a comprehensive individual risk assessment during their pre-assessment which included nutritional assessment. We reviewed seven patient records which showed that patient's nutrition and hydration status needs were assessed and met. Staff told us they physically assessed the patients and calculated Body Mass Index (BMI) and hydration checks were part of vital signs.

We observed a consultation where the patient was given advice on fasting before a procedure by the consultant with appropriate leaflets.

Although the waiting area only had a water dispenser, staff told us patients could request tea and coffee which the staff would obtain from the staff kitchen. Patients could also order food if their wait time exceeded three hours. This included food options for diabetics. Staff told us the appointment letter advised patients that a three hour visit was a possibility.

Patients received vitamins and nutritional pre-operation drinks before their surgery with clear instructions. We observed staff giving patients refreshments on day unit following the endoscopy.

Pain relief

Staff told us pain discussions took place during preassessment. Staff went through pain management to determine what the patient was already taking and then provide patient education on pain relief. Staff also provided advice on what to do if patients ran out of their pain medication. Staff told us that if needed, a patient could be referred to the pain clinic at the local NHS trust.

We observed a consultation where the consultant asked a patient about pain management and reviewed their current medicines. The consultant asked the patient if it was a good day or bad day and to provide a pain score.

Patient outcomes

Each clinician/healthcare professional had the responsibility to record outcomes in the patient record as soon as possible. The governance manager ensured the accuracy of patient outcome information. The centre reported KPIs centrally as part of the monthly business review and key elements and trends were shared at the QGA meetings. The service also shared outcomes with the clinical commissioning groups (CCGs) in quarterly meetings as contract compliance checks.

The centre collected Oxford Knee Scores (OKS) and Oxford Hip Scores (OHS). The OKS questionnaire consisted of 12 questions that covered the function and pain of the knee.The OHS questionnaire was a short12-item survey with a recall period of four weeks, assessing pain and function of the hip in relation to daily activities. Between April 2017 and March 2018, the service performed within expected range, compared to national averages, for OKS and OHS.

The service provided KPI data for endoscopy between January 2018 and December 2018. The service consistently achieved the target of 90% or more for colonoscopy completion rates. For successful intubation for gastroscopy, the service consistently achieved 95% or above except for March and April with 93.1% and 94.7% respectively.

Competent staff

Between October 2017 and September 2018, 100% of nursing staff and health care assistants (HCAs) had received an appraisal. The appraisal year ran from October to September. The staff we spoke with during the inspection told us they had their appraisals annually. At the time of our inspection, 90% of nursing staff and 100% of HCAs had received their appraisals.

The senior leadership team told us the head of professions was the organisational lead for professional revalidation whilst the head of nursing was the lead locally. Line managers supported nursing staff with the revalidation process.

Staff told us that although clinical supervision for nurses took place, it was not formally recorded. However, to address this, the lead nurse had recently introduced lunchtime meetings which allowed protected time for clinical supervision and communicating any service updates. During induction, all new consultants had supervision established with corporate lead consultants before doing any clinics of their own and the clinical governance coordinator kept a supervision record.

The lead nurse told us each nurse had their own record of competencies. Nursing staff told us that routine competencies were completed annually.

Nursing staff told us they had good access to training which was often provided by the consultant anaesthetist. Staff provided recent examples of training which included airways management, which was face to face with a consultant, and ophthalmic biometry training. Training events were incorporated into departmental meetings. For example, staff also told us they had completed electromyography (EMG) training. EMG is an electrodiagnostic medicine technique for evaluating and recording the electrical activity produced by skeletal muscles.

The service developed their staff providing training for specialist skills. For example, the service had supported an opthalmic nurse to develop further which meant they could run nurse-led opthalmology clinics. During the inspection, staff told us the anesthetist was supporting the pre-assessment nurse to learn new skills so that they could provide nurse-led anaesthetic clinics. This meant patients could have their pre-assessment and anaesthetic assessment in one appointment with the nurse, speeding up the patient journey.

The service had a comprehensive induction checklist for all new employed staff, which included locum and bank staff. The induction checklist was completed over 12 weeks and included what to do before the start date and day of arrival, mandatory training, safeguarding including prevent, opportunities to raise any concerns or issues, communication and information technology. The mandatory training section had to be completed in the first two weeks. All staff also received a local induction which involved meeting all the departments and service leads.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Good

Outpatients

The centre offered patients one-stop clinics which involved different disciplines of staff. The multidisciplinary team approach during pre-assessment could involve seeing a nurse, HCA, consultant, anaesthetist and radiology at the adjacent acute hospital. Where applicable, patients often received their date for surgery during the same visit which improved convenience for the patient with less visits to the centre. The centre had a service level agreement (SLA) with the imaging department at the acute hospital and other external providers. Patients were able to get their X-rays done on the same day as part of the one-stop clinic using a generic outpatient form. Staff told us consultants had instant access to the images electronically at the clinic.

There was an effective multidisciplinary team (MDT) working environment within the OPD service. Staff worked closely across teams to ensure a smooth patient journey. The patient pathway co-ordinators ensured that patient appointments were managed effectively within the department by liaising with the medical records team, interpreters and nursing staff. There was also close working across departments. Nursing staff told us they had good working relationships with the consultants who were always accessible.

Physiotherapy had recently been brought in-house and the service was working towards setting up external clinics to develop the physiotherapy service further. Physiotherapy and occupational therapists (OT) were based on inpatient ward and they reviewed patients post hips and knees. Patients could also access the wound clinic which was based on site.

The endoscopy team had developed close links with the local trust multidisciplinary team (MDT) to ensure the service had an effective patient pathway for cancers that were detected. If a patient was diagnosed with cancer through the pathway, the patient was immediately referred into the two week cancer pathway with all the appropriate information such as images, bloods taken on the day and biopsies. The administration staff would ensure this was done and received an acknowledgement from the local trust immediately. The endoscopy team had a dedicated staff member who was responsible for tracking specimens. This included the input, checking and follow up of specimens. Staff told us that if a surgeon had an urgent specimen, it would go to the local trust immediately. The service had an agreement with an external independent health provided for general pathology.

Seven-day services

The service scheduled OPD clinics from 08.00 to 21.00 Monday to Friday and 08.00 to 18.00 on Saturdays. Staff told us most specialities offered evening and weekend clinics. For example, orthopaedic clinics took place on specific evenings and gynaecology clinics took place on Saturdays. Patients reported good access to appointments at times which suited their needs. Staff told us the clinics did not finish late often and they could only remember two occasions where the clinics overran until 10pm.

The pharmacy service operated from 08:00 to 16:00 hours between Mondays to Fridays and was closed at weekends and public holidays. There was a pharmacist on-call for requirements outside of normal working hours who could be contacted via the on-call manager. The pharmacy team told us they would prepare in advance for OPD clinics and would use prelabelled medicines.

The service offered patients a 24 hours, seven days a week advice line which was manned by nursing staff on the inpatient ward during the day and the resident medical officer (RMO) during out of hours. Nursing staff either reassured patients or brought them back for assessment and/or re-admission with reviews by the RMO and a consultant as needed.

Health promotion

Each patient was asked whether they smoked during their visit to OPD. We observed preassessment appointments where staff provided advice on stopping smoking and the patient was signposted to community services for support. Staff also gave advice to patients on weight reduction, regular exercise and diet.

We also observed a thorough nurse led preassessment where the patient was given advice on reducing alcohol consumption.

Consent and Mental Capacity Act (Deprivation of Liberty Safeguards only apply to patients receiving care in a hospital or a care home)

Good

Outpatients

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

The corporate safeguarding policy covered Deprivation of Liberty Safeguards (DOLs) and the Mental Capacity Act 2005 (MCA). Data provided by the service showed the overall staff training compliance rate was 93.4% for MCA and DoLs and 97.7% for consent, against a target of 95%. Most staff showed awareness of MCA and DoLs. Nursing staff told us they would complete MCA referrals under the guidance of the safeguarding leads as the need to apply it in practice was infrequent. HCAs told us they would refer to nurses if they felt something wasn't right.

The patient's capacity to consent to treatment was assessed at the initial appointment and throughout the patient journey. Where it was suspected that a patient lacked capacity, a mental capacity and best interests' assessment was undertaken.

We observed nurses giving patients information leaflets that explained their upcoming procedure, and any benefits and risks in detail. This gave patients more time to consider the information and implications of their surgical procedure prior to giving consent. Staff told us consent was taken during pre-assessment clinics and on the day of the procedure. As of June 2018, endoscopy patients received their pre-assessment on the telephone which meant consent was taken on the day of the procedure by the consultant. In all seven of the records we reviewed, we found consent forms had been signed.

Are outpatients services caring?

Good

Our rating of caring stayed the same.We rated it as **good.**

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

During our last inspection, we found staff conversations in Barley Court could be overheard through a shutter that separated the waiting area and staff kitchen. On this inspection, we found the outpatient department (OPD) had been reconfigured which meant all OPD clinics were held on the main site. Confidential discussions were a challenge at times given the space limitations and staff relied on clinic rooms being free as there was no other space available. Although the nurse station was located next to the waiting area, on most occasions we did not hear any confidential conversations between staff during our inspection. However, on one isolated occasion, we observed nurses discussing patients and although this was done in a low voice, due to the cramped space, parts of their conversation could be heard.

Patients and relatives we spoke with consistently told us about the kindness of staff in outpatients. The following was representative of the feedback we received: "Staff are friendly and helpful", "This is excellent", "I wait no time at all for the appointments" and "Staff do a wonderful job, "It has been a quick process from referral" and "Staff respected my privacy".

Staff paid attention to maintaining patients' dignity, privacy and respect. Doors to patients' rooms were closed and privacy curtains were drawn when personal care or clinical examinations were carried out. All of the patients we spoke with told us doctors' respected privacy with curtains and took the time to explain things well. We observed good interaction by all grades of staff including consultants with patients. Staff members did not rush patients during appointments and engaged with patients providing reassurance when necessary. For example, we observed a staff member ask a patient which arm was better for them for a blood test. We also observed an endoscopy patient being discharged and found comprehensive information was given to the patient post procedure and patient confidentiality was maintained as the conversation could not be overheard from the next bed.

Good

Outpatients

Although all the patients we spoke with praised the nursing and medical staff, the complaints log showed there were some isolated complaints where patients complained about the attitude of nursing and medical staff describing them as rude.

The centre used hand-held tablets and a computer kiosk for recording friends and family data. We observed staff members ask patients to complete electronic feedback during their patient pathway. However, the kiosk had been out of order for one week, although staff told us it had been reported. Patients we spoke with told us they would recommend the OPD service to their families and friends and most of the patients were pleased with the waiting times.

During the last inspection, we found the response rate for the friends and family test (FFT) results warranted further improvement. On this inspection, the service told us the recent reconfiguration of the OPD department had impacted on the response rate for FFT. The service provided overall FFT results between May 2018 and October 2018 which showed the scores ranged from 97 to 98%. However, the response rates between the same activity period had improved. For example, in September 2018 the response rate was 40% compared with 90% in October 2018.

We asked the service to provide FFT scores for OPD and endoscopy specifically. Between July 2018 and December 2018, an average of 95% of patients would recommend the OPD service, against the NHS threshold of 94%. Although the percentage response rate reduced to 28% in August, data showed improvement with the service achieving 76% in November 2018. However, this figure dropped to 51% in December 2018. The endoscopy FFT scores showed that the percentage of patients who would recommend the service was consistently 98% or higher between July 2018 and December 2018. During our inspection, we saw the FFT results displayed in the outpatient waiting area for visitors to view.

The service provided the results for the May 2018 Patient-Led Assessments of the care environment (PLACE) programme. The graph results for privacy, dignity and wellbeing showed the service performed lower (approximately 80%) against the national average of approximately 83%.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff supported patients to manage their care and treatment. For example, we observed an appointment where the consultant was calm and sympathetic towards the patient and asked the patient about what they would like to happen and their views of the procedure. The consultant also asked the patient about their environment at home and outdoor access during a discussion around post operative care. The consultant explained the waiting times to patient and listened to both patient and family, focussing on the patient. All staff showed excellent communication skills during the consultations we observed, allowing each patient to have enough time to ask any questions.

We observed chaperone posters in each OPD clinic room. Staff told us the nursing staff allocation for each day ensured each consultant had a chaperone.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We observed reception staff welcome patients in a polite and respectful manner despite being busy. Some patients had previously visited the centre and said it was a good service.

We spoke to patients across all of the OPD areas and endoscopy patients in the day unit. All of the patients we spoke with felt involved in their care and expressed confidence in their care teams. Patients felt involved in the decision making process of their care and felt fully informed of their procedure. We observed pre-operative assessment staff come in the waiting area to call the next patient. Staff called out the patient's name, introduced themselves by name and role, and then led them through. We observed staff interacting with patients in a friendly and polite manner.

Although staff told us the service had become more busier and waiting times were not displayed in the waiting area, most patients we spoke with told us they hadn't waited long for their appointments. Patients we spoke with told us they received reminders for their

appointments via text and a phone call. Patients told us they had clear instructions of where to arrive for their appointment and they found the centre was easy to find and car parking was not an issue.

Patients told us communication with staff was good, with full explanations provided by staff to the patients and their relatives as to what they will be doing. We observed a consultant introduce himself in a welcoming manner to the patient. The consultant did not use jargon and explained the aim of the appointment before asking the patient about allergies, taking a full medical history and providing advice on stop smoking. The consultant gave advice regarding the weather and taking care to avoid slipping. The patient was advised to use a walking stick instead of crutches and provided with an explanation of the impact on the joints.

However, staff told us that as there was only one waiting area for OPD clinics and admissions for the day unit and surgery which meant OPD staff found it hard at busy periods, to know who their patients were. Staff told us this wasn't an issue at their previous site as the space was much larger. We spoke with one patient who was anxious whilst waiting and we raised this with staff who addressed it immediately by seeing the patient straight away.

We observed a patient who presented with a knee pain but also mentioned a shoulder problem. The consultant was able to speak to their peer who specialised in shoulders and immediately referred the patient to him, who then examined the patient and administered an injection in the joint. The patient left happy as all their concerns had been addressed in one go. The patient told us that the results for a recent imaging tests were available for the consultant during the appointment.

Are outpatients services responsive?

Good

Our rating of responsive stayed the same.We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

The outpatients department provided clinics for a range of different specialities including trauma and orthopaedics, general surgery, ophthalmology, gastroenterology, gynaecology, urology and ear, nose and throat (ENT). Although ENT clinics took place off site, staff told us the service was planning to offer these clinics on site from March 2019 once the appropriate equipment had been acquired.

The service worked collaboratively with the clinical commissioning group (CCG) and the local trust next door to reduce waiting times for patients in specialities such as neurosurgery and endoscopy. The service had plans to extend this to orthopaedics and ophthalmology in the future. The service also worked with local referral management centres.

Although wound clinics did not form part of the centre's contract with the CCG, the service still provided wound clinics to meet the local needs of the community. The service reviewed 1,500 patients each year in this capacity and continued to work with the CCG to improve wound clinic care in the community.

During our last inspection, car parking was the dominant issue raised in patient feedback due to cost and availability of spaces. Staff had also raised similar concerns. On this inspection, both patients and staff told us the car parking facilities had improved. The senior leadership team told us the service had acquired more parking spaces.

The centre was easily reached by public transport. There was a regular bus service close to the outpatients department that linked to the local area and underground station. The main site for the centre had clear signage outside for patients. Signs inside clearly showed where different areas were. For instance, reception, waiting area and clinic rooms were all well sign posted.

The facilities and premises were suitable for the services planned and delivered. The waiting area included drinking water and a television at a volume that was not intrusive to the waiting area. Staff told us the service used to have a tea and coffee machine which was removed due to health and safety. However, teas and coffees were available on request from the staff kitchen. Although the waiting area did not have any toys for children, we observed one patient waiting with a child who requested

to use the WiFi and staff assisted them with this. There were toilets available that included accessible toilets and a baby changing table. The centre had wheelchair access into the main reception and a lift to the first floor to the inpatient ward.

Most of the specialities offered evening clinics. For example, orthopaedics and endoscopy ran a number of evening clinics and saturday clinics to provide patient choice. Patients told us that they found the appointment system flexible as they could choose the appointment time convenient for them.

Although the waiting area had no reading materials like magazines, the service displayed patient information leaflets. For example, we saw a leaflet on flu and how to make complaints. We also saw leaflets on procedures in multiple languages in the waiting area. For example, the total hip replacement leaflet was available in English, Bengali, Polish, Portuguese and Mandarin whilst the total knee replacement leaflet was in English and Arabic.

The service used an external provider to produce their patient information leaflets. Staff told us that leaflets could be printed in 36 different languages for all procedures.

Patients had access to physiotherapy and occupational therapy leaflets. Staff told us that patients could access an easy to use smart phone application for physiotherapy exercises which including preparing for and recovering from orthopaedic surgery.

Meeting people's individual needs

The service took account of patients' individual needs.

Following the results of the May 2018 Patient-Led Assessments of the Care Environment (PLACE) audit, the service had made some changes to the environment to support patients with dementia. For example, at pre-assessment, staff would identify any patients with dementia who were being admitted and notify the ward manager who arranged the patient's admission and identified any one to one support that was required.

The service was in the process of implementing a dementia strategy which set out how the service will work with their patient's, carers, staff and partners to deliver dementia care that is consistently high. Staff told us the service had assessment forms for dementia and mental health. The service encouraged family members and relatives to stay with dementia patients. If known in advance, the triage nurse booked extra clinic time for patients living with dementia or a learning disability. The service had an information leaflet for patients with dementia and their families/carers which explained their stay in the centre.

The endoscopy service had a separate morning and afternoon list which was split by gender. For example, the morning list would be for female patients and the afternoon patients would be for male patients (or vice versa). The endoscopy suite had a private room which was used to speak with patients in privacy. Endoscopy patients received their pre-assessments by phone to avoid unnecessary visits to the centre. The service changed the endoscopy preassessment process in June 2018 in conjuction with the CCG.

The service staggered admission times so that patients were not waiting too long before their procedure. One patient we spoke with told us they had been asked to come in earlier for their outpatient appointment and were seen straight away.

The service used face to face interpreters as well as staff who spoke numerous languages. Staff told us they would not use friends and family. The service also had access to a telephone translation service but preferred to use face to face interpreters. Staff told us they could also call on the chaplain from the local trust if need be. We observed an appointment where a patient needed to be re-booked with an interpreter. However, staff realised an interpreter was on site for another appointment. Therefore, the consultant was able to see the patient on the same day stopping them from having to come back.

Access and flow

People could access the service when they needed it.
Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

The service was an elective treatment centre which meant patients were referred to the service by the GP using the NHS E-referral system (eRS) or via a manual system (letter or fax). Staff told us the appointment slots opened six weeks in advance and some buffer slots were released one week in advance. There were dedicated slots for first appointments and follow up post

diagnostics scans and procedures which worked well for the patient pathway. The patient services team told us the referral would take three days to go through the triage process.

The triage team chased any missing information and completed a referral audit form which logged the patients' NHS number, the date the triage was received and signature, patient pathway coordinator input and medical records checks.

Patients received appointment letters as the first correspondence after the referral has been triaged. Each patient received a preappointment call five days before their appointment. If the patient was not in, the staff member would continue to call daily until contact was made. Patients received appointment reminders via text message 96 hours before the appointment. The generic text included details on the location, time and date of the appointment without patient identifiable information. If patients opted out of the text service, they would receive a call. The senior leadership team told us the service was looking to improve the text message system to include human factors. Although the human factors training was ongoing during our inspection, staff we spoke with demonstrated good awareness and could articulate what human factors was all about.

Staff told us that blood tests results came back quickly. The centre had a dedicated staff member who received a list of all the tests taken at the end of each day so that the results could be checked or chased. The physiotherapy team reviewed all hip and knee replacement patients for six weeks post operatively to monitor the patients progress. Patients also received a three month review with the physiotherapy team.

The centre had a service level agreement (SLA) with the adjacent NHS hospital and could access the images instantly on the shared system. The centre also had their own picture archiving and communication system (PACS) system which covered computerised tomography (CT), Magnetic resonance imaging (MRI) and ultrasound. At the time of our inspection, the service was renegotiating their PACS SLA with the local trust with the aim to get images uploaded on the centre's PACS system.

During the last inspection, patient feedback indicated the waiting times for the one stop clinics needed to be addressed and recommended that the service should keep the patient fully informed of the waiting times when they attend to manage expectations. On this inspection we found this had improved as the average wait time had reduced to 47 minutes in December 2018 from 63 minutes in July 2018.

The centre offered a one stop clinic where patients were seen in outpatients by the consultant and had a nurse led pre-assessment with diagnostics. The service's target was to provide a comprehensive consultant led service that allowed the patient to be seen and accepted for surgery in a 3 hour appointment slot. Staff told us that although the appointment letter for the one stop clinic advised patients to allow 3 hours. Staff told us every effort was made to book the operation with same surgeon who did the assessment.

The service was able to extract data directly from their information management system and review the days and times where they failed to reach the patient expectations, ensuring actions were taken to avoid reoccurrence. For example, the senior leadership team used the information management system and identified that diagnostic services was creating delays for patients. The service reviewed their SLA with the local trust and acknowledged that any delays the local trust had, impacted on their patients. To mitigate this, the service agreed SLAs with three additional external providers which provided more patient choice and reduced the waiting times. The service developed a generic diagnostic form to help manage patient flow more efficiently with multiple providers.

The service provided the diagnostic performance data for endoscopy which had a target of 98% within six weeks. Although the service's performance was just below the target between July and October 2018, the service achieved 99% in November 2018.

The service delivered an 18 week referral to treatment pathway and the senior leadership team told us the service was meeting national waiting times. The service provided data which showed all specialities routinely achieved below 10 weeks for average RTT between December 2017 an November 2018. The service's website advertised live waiting times for clinic appointments for patients to access. At the time of our inspection, the waiting times for the first appointment was two weeks for general surgery, foot and ankle surgery, hand and wrist surgery, hip and knee surgery; three weeks for eye surgery

and urology; two to three weeks for endoscopy and four to six weeks for gynaecology. The service provided data which showed that between July 2018 and January 2019, the average number of weeks from referral to first outpatient appointment was 2.14.

The service had reduced their 'do not attends' (DNA) rates. For example, DNA was 7.5% in August 2018 and since implementing the pre-appointment call in September 2018, the DNA rate had reduced to between 2 to 3%. The aim of the pre-appointment call was to confirm the patient's attendance and to determine if any additional tests had been carried out so that the results could be chased in time for the appointment. This meant previous images could be obtained for patients reducing the need to be exposed to radiation again.

The patient pathway coordinators managed cancellations. Staff told us cancellations were rare and only if the consultant was sick. Staff told us consultants added on patients who needed to be seen at the end of their list. On the day cancellations were reviewed by the governance lead. If a cancellation was for a clinical reason, the patient would be passed onto the clinical lead for review. The patient would be rebooked within one or two weeks and not put at the back of the queue. The service reviewed cancellations bi-weekly to understand themes. Between November 2018 and January 2019, two out of 577 sessions (0.3%) were cancelled due to the consultant facing unexpected travel issues. Although the service arranged for another consultant to see the most of the patients, some appointments were rescheduled.

The centre had one medical secretary who completed GP letters using the consultant's electronic clinical summaries from clinics. A hardcopy of the GP letter was printed for the patients file. Staff told us the turnaround time for clinic letters was two weeks but the service was aiming to get to one week. Between October and December 2018, the average clinic letter turnaround times was 2.7 days.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The centre received 45 complaints overall between November 2017 and October 2018, of which one complaint was referred to the ombudsman. The centre had a corporate policy for managing complaints which stated formal complaints were acknowledged within three days of receipt. The service would fully investigate and respond within 20 working days. Where the timescale could not be met, the patient would be contacted via their preferred method of communication and provided with a reason for the delay and an expected date of response would be agreed. The hospital director reviewed the root causes identified and agreed the final letter and was responsible for signing off the final version of the response. The senior leadership team and staff told us that learning from complaints was shared with all staff at the QGA meetings.

The centre displayed the corporate complaints leaflet in the waiting area. The leaflet explained the process to patients and made reference to the three stages and who to contact for each stage. Staff we spoke with showed awareness of complaints procedure.

Are outpatients services well-led?

Good

Our rating of well-led stayed the same.We rated it as **good.**

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The senior leadership team included the head of nursing, hospital director and medical director. Although some members of the senior leadership team were relatively new, senior leads told us the team felt more stable with a collegiate team.

Most staff we spoke with told us the head of nursing and deputy hospital director were approachable and visible with frequent walk-arounds and had an open door policy. However, some staff showed inconsistent awareness of senior leads. Staff received weekly whereabouts communication to let them know which members of the senior management team were on site should staff have any queries.

Good

Outpatients

All of the staff we spoke with told us they felt supported and listened to by their line manager. Staff told us they felt valued and spoke positively about the nursing leadership. Staff felt encouraged to challenge where appropriate.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

The centre had a Growth Strategy which aimed to be the number one partner to the NHS for elective surgery. The centre had a Growth Plan for 2018 which focussed on improving and maintaining clinical quality and patient experience, recruiting and retaining high quality staff, growing the business, delivering performance improvement and optimising the efficiency of the technology and estate.

Staff we spoke with were committed to providing good care to their patients and demonstrated awareness of the values of the service. The senior leadership team commended staff for maintaining high standards of care despite the space limitations resulting from the service configuration.

The centre offered clinics in the local community, for example, the ear, nose and throat (ENT) outpatient appointments at two local GP led health centres.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

We found an inclusive working culture within the outpatient department. Staff we spoke with described the culture as 'wonderful atmosphere', and 'friendly'. We found highly dedicated staff who were positive, knowledgeable and passionate about their work. The service was embracing human factors training to continue fostering an open and transparent culture.

Staff we spoke with told us they felt cared for, respected and listened to by their peers and managers. Staff told us there was good rapport between nurses and doctors which facilitated effective teamworking and a welcoming working environment. Staff we spoke with told us they felt able to challenge unsafe practice and report them to the manager. Staff told us they received debriefs where necessary although staff also said they rarely had difficult encounters with patients.

Senior leaders felt proud of their teams for making a positive difference to their local communities. Senior leaders told us staff were committed, flexible and respectful to patients and colleagues. The provider had an annual award ceremony to award staff. Senior leads told us three staff members from the centre had won last year.

The service provided psychological support for staff through support from line managers, shift leaders, access to the employee assistance programme and occupational health where needed. Staff also had access to face to face counselling support, post trauma support or critical incident management through self-referral to an external provider.

The service provided the action plan for OPD further to the 2017 "Over to You" survey. Although the action plan included a point regarding discrimination at work, all of the staff we spoke with told us they had not experienced or witnessed any discrimination at work. The lead nurse told us the discrimination at work issue was in relation to theatres.

The Human Resources (HR) Director was the Freedom to speak up guardian and was responsible for ensuring the on-line library of resources was current, relevant, and helpful. Staff could also contact an independent charity to obtain confidential advice.

Care UK had an established Equality, Diversity, and Inclusion Steering Group, chaired by a member of the Health Care Executive team. The hospital director attended the quarterly meetings and fed back messages to ensure that the centre actively promoted an open and fair culture free from discrimination, harassment, and victimisation.

Staff at the centre had access to My Care UK's Equality, Diversity and Inclusion dedicated webpage that provided comprehensive resources advising line managers how, as an employer, to approach all the protected characteristics. The completion rate for the mandatory Equality and Diversity training was 95.54%.

The centre had an ongoing action plan in relation to wider Equality and Diversity issues which included the Workforce Race Equality Standard (WRES) objectives. The centre had completed a review of nursing pay scales to ensure that there was parity for all staff. The e-learning system had been updated with "Develop Me" modules to ensure managers had appropriate training with regards to fair recruitment and selection.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

The service had a clinical governance policy which covered roles and responsibilities. Clinical speciality leads met monthly and aligned their meetings with the quality governance and assurance (QGA) meeting. Care UK had a bi-monthly corporate meetings for secondary care at the head office to identify the pitfalls that each centre was facing. The clinical leads which included nurse and medical leads, had their own bi-monthly forum with the corporate chief nurse where learning and good practice was shared. We reviewed the October 2018 Secondary Care Quality Governance Report which showed comprehensive corporate discussions took place regarding the governance dashboard and key performance indicators (KPIs) for all of the Care UK locations.

The service outsourced several services and the senior leadership team told us service level agreements (SLAs) were reviewed nationally at Care UK, not just locally. The head of nursing had developed an operational policy to ensure pathways were mapped as to how the service understood them which helped the service ascertain the effectiveness of SLAs.

The senior leadership team told us that quality and governance was a focus for all staff. The centre suspended clinical activity bi-monthly for QGA meetings and all staff were invited to attend. Staff told us consultants also attended as part of a multidisciplinary team as they were directly employed. The meetings were well attended and took place over a full day with half the day dedicated to governance followed by a departmental team meeting for the rest of the day. The leadership team were always present at the QGM as they felt it was important for staff to get key messages from the triumvirate. Staff told us they felt comfortable raising concerns at the QGA meetings.

We reviewed the minutes for the June 2018 QGA meeting which showed 65 staff members attended and where apologies were given, a reason such as annual leave or sick leave was noted. The meetings started off with an update from the hospital director on both local and corporate matters followed by an opportunity for staff to ask any questions or discuss any concerns. The rest of the senior leadership team also provided an update followed by the clinical leads for their respective speciality. The senior leadership team told us the the governance aspect of the meeting had a set agenda which included safeguarding, complaints, incidents, key performance indicators (KPIs), mortality and morbidity, infection prevention and control, patient experience and involvement, health and safety, learning and development and retention and recruitment. Staff we spoke with told us they received feedback from incidents and complaints at the QGA meetings.

Heads of departments (HODs) met monthly and had away days on a quarterly basis. We reviewed the HODs monthly meeting minutes provided by the service from August 2018 to November 2018 and found there was consistency in the format and structure of these meetings. We found each department provided an update for their respective area and each agenda item had an action required noted with an assigned owner.

The OPD department had team meetings which took place monthly. We reviewed the November 2018 minutes which showed staff received updates regarding the new VTE guidance, response rates for patient surveys, service updates, sharing learning and mandatory training.

Managing risks, issues and performance

During the last inspection, staff raised concerns around security. The service had completed a risk assessment and addressed the concern. Staff told us the centre had dedicated security staff from 7pm to 7am but not during the day. The treatment centre had CCTV throughout and there was a panic alarm behind reception and call alarm bells in each clinic room. The service had a lone working policy and staff we spoke with told us they had not witnessed any difficult behaviour. Staff requested to see

our identification during the inspection when we re-entered the building. The lead nurse told us that staff would contact the police during the day if there was a security concern or staff could seek help from the local trust next door. Senior leads told us that all staff had completed the mandatory managing conflict training. The service had also arranged provisions for personal panic alarms for employees as additional security.

The service provided the corporate risk register which included broad risks with generic actions. We requested the OPD and endoscopy risk register and found risks were logged appropriately and included a date of last review, risk analysis, further action taken and details of who owned the risk. The OPD risk register had eight risks from which three were classed as low and four were classed as medium. There was one high risk which concerned staff security in the car park and the service had taken appropriate steps to mitigate this risk.

OPD staff, including the lead nurse, could not articulate what was on the risk register for the department. Staff we spoke with had mixed reviews about the service reconfiguration. Some staff felt that although space was limited, the layout worked. However, some staff told us they felt the size and space of department was a risk. The senior leadership team acknowledged the space constraints and told us there was still some way to go but said the service was moving in the right direction. Although the service had completed a fire assessment action plan as part of the OPD reconfiguration, senior leaders told us the local fire brigade was due to visit next week to complete a fire assessment further to the reconfiguration.

The quality and governance manager led on audits. The service had a monthly audit programme which was displayed in clinical areas in the form of an audit calendar. The provider also had a national health and safety manager who was responsible for business continuity. The service completed risk assessments and prioritised the services using RAG ratings, where red meant absolute necessary. The senior leadership team told us the service had a major incident plan which senior leaders reviewed regularly. Staff provided an example of how the service had dealt with a major incident which involved ensuring the safety of staff and patients in the building further to a police incident in the area. Senior leads kept staff and patients informed of the actions taken by the service.

The service used an electronic tool to review clinic utilisation, bookings and theatre utilisation. The patient services team received daily reports from the data analyst which showed the number of appointments, triages and outcomes outstanding.

The OPD department completed monthly health and safety reports. The service provided the reports for January to April 2018, June to July 2018, October 2018 and December 2018. We found that although the checklist was comprehensive, the action plans in both reports were not completed for the risks identified. Therefore, it was not clear what action had been taken to address them.

The service had a weekly meeting to review the operational metrics. Attendance included the hospital director, deputy hospital director, head of nursing, patient services manager and data analyst. The finance manager also attended on some occasions. The weekly operational report was presented in patient groups at different points of the patient pathway. The data was split by speciality. Example of patient groups included first appointment booked versus not booked, subsequent appointment not booked and whether this was due to awaiting diagnostics or not, subsequent appointment booked, suitable for surgery, procedure not booked (ready to go) or procedure booked. The service used this as an opportunity to review their currently SLAs with providers as well. For example, having noticed people waiting a long time due to diagnostics, the service secured three additional SLAs with external providers to provide a diagnostic service.

The collection of clinical outcomes, key performance indicators (KPIs) and CQUINS were reported and reviewed internally monthly and reported externally to the commissioners on a quarterly basis.

Managing information

Although staff could access policies on the intranet and shared drives, some staff told us the system could be slow at times. We asked staff to show us where to find

certain policies and we found staff awareness of accessing policies on the intranet was inconsistent and some PDF files did not open. Most staff accessed policies on the shared drive.

A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. The medical director was the Caldicott Guardian for the service.

All eight of the OPD clinic rooms and the nurses station had a computer. The lead nurse told us there were plans to create another space for one more computer for nursing staff to use. Although a computer had been bought, discussion was still ongoing regarding the location.

The service had access to the information technology corporate support team 24 hours a day. Staff told us the information technology (IT) systems were generally reliable, although some staff have had some user issues. The centre shared the local trust next door's IT connectivity which meant the consultants could access the local trust's system to access pathology and radiology results easily.

Although the OPD department were waiting for a notice board, the department were currently sharing the administration teams notice board behind the reception desk. Information on the notice board included posters on preventing norovirus and influenza, information on the centre's fundraising, incident report and dates for QGA meetings. We also saw a poster on 'Stop for safety' which aimed to improve the culture across all the services at the centre.

Staff told us that accessing the e-learning for mandatory training had improved and the service had a dedicated staff member to provide support staff with the system.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The service had an active staff forum led by the hospital director, on a quarterly basis. The forum allowed staff to give their opinions and have their voices heard and acted upon. Each department had a designated person who attended and fed back to the rest of the team. Staff told us minutes for the forum were stored on the shared drive. Issues raised were also discussed in departmental meetings and QGA meetings.

We reviewed the minutes for the November 2018 forum which showed that each department provided an update for their department. The minutes also included an action log which included action points, a designated responsible person, due date and outcome for each agenda item.

During our last inspection, staff told us they had concerns around the car parking. This had also been highlighted in the 2017 Over to You Survey results for OPD. On this inspection, we found improvements had been made. The service had addressed this by acquiring additional parking spaces.

Staff told us they received communication via emails for corporate updates and by the hospital director at QGA meetings.

The patient forum met twice a year and were involved in various governance and centre activities including participation in the 2018 PLACE audit. The senior management team provided a service update at the start of each meeting including information on service development, activity levels, quality update, capital investment and other fabric improvements.

The service also reviewed patients' feedback on websites such as NHS choices and the Care UK Microsite. Comments were responded to and action taken if required.

Learning, continuous improvement and innovation

The latest service development at the centre was to provide soft-tissue surgery having identified a need in the community. The service worked collaboratively with the CCG and local trust to implement this service. The senior leadership team told us the centre had started day case procedures for the knee and had also completed two hips and two shoulder procedures. The process was patient specific and led by a multidisciplinary team.

Outstanding practice and areas for improvement

Outstanding practice

- The extensive audit programme allowed early identification of areas for improvement, action plans were put in place as a result of any non-compliance.
- Staff comprehensively completed and updated risk assessments for each patient.
- The centre suspended clinical activity every two months for quality and governance meetings and all staff were invited to attend. The meetings were well attended and took place over a full day with half the day dedicated to governance followed by a departmental team meeting for the rest of the day. The leadership team were always present at the quality and governance meetings as they felt it was important for staff to get key messages from the triumvirate. Staff told us they felt comfortable raising concerns at the QGA meetings.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that there are significant improvements in communication between the bookings and theatre team and the theatre and recovery teams.
- The provider should ensure that, except in exceptional circumstances, patients operations are carried out by the same consultant who carried out their initial consultation.
- The provider should ensure the outpatient department displays the NHS safety thermometer (or equivalent) for staff or patients to view.
- The provider should continue making progress on increasing the number of Friends and Family responses it receives.
- The provider should ensure staff awareness of Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) is consistent.
- The provider should ensure staff awareness of senior leads is consistent.

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.

This section is primarily information for the provider

Enforcement actions

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.