Manchester Surgical Services

Quality Report

Surgical Unit, Trafford General Hospital
Moorside Road, Daveyhulme
Manchester M41 5SL
Tel: 0161 746 2433
Website: www.manchestersurgicalservices.co.uk

Date of inspection visit: 2, 4 and 17 March 2017
Date of publication: 19/07/2017

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?	**Requires improvement**

Overall summary

Manchester Surgical Services is an independent healthcare provider based at Trafford General Hospital within Trafford Healthcare NHS Trust in Trafford, West Manchester. The service operates in a collaborative partnership with Trafford General Hospital, who are the facility provider for their clinical pathways.

The main service provided by this service is surgery. There are outpatient services, but these are limited to initial consultations, pre-assessment appointments, post-operative appointments and pain management. There are no general outpatient or diagnostic services provided. The service provides treatment for NHS patients that includes general surgery, orthopaedic surgery and ear nose and throat surgery. There is also an endoscopy service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 2 and 4 March 2017, along with an unannounced visit to the service on 17 March 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

Summary of findings

are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

We rated this service as good overall.

We found the following areas of good practice:

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Staff assessed and responded to patients' risks and followed the 'five steps to safer surgery' procedures during surgery.
- Care and treatment was delivered by staff working under casual worker arrangements and consultants under practicing privileges. The staffing levels and skills mix was sufficient to meet patients' needs.
- There were no serious patient safety incidents, healthcare-acquired infections or surgical site infections reported in relation to the service between January 2016 and December 2016.
- Staff followed the host hospital's policies and procedures relating to medicines management, infection control and maintenance of the environment and equipment. Patient records were completed appropriately.
- Most patients received treatment within 18 weeks of referral and waited less than 6 weeks from referral for a diagnostic test. The service monitored performance against waiting time targets to reduce delays in treatment.
- There were only four operations cancelled for non-clinical reasons between April 2016 and December 2016. All the patients were treated within 28 days of the cancellation date. There had been no new or follow up appointments cancelled by the service within two weeks of the appointment date between April 2016 and December 2016.
- There were processes in place to protect vulnerable patients and those identified at risk of abuse. Patients understood how to make a complaint or raise a concern and their concerns were listened to.
- We spoke with 12 patients and the relative of a patient. They all spoke positively about the care and treatment they received. Patient satisfaction surveys also showed patients were positive about the services provided.
- Patient consent was obtained prior to commencing treatment. Patients were involved in their care and staff provided emotional support when needed.
- The services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. Patient outcomes were measured through patient feedback and the routine monitoring of key processes.
- Care and treatment was provided by suitably trained, competent staff who worked well as part of a multidisciplinary team. All the core staff had completed their appraisals. The majority of staff had completed their mandatory training.
- The service had a clearly defined vision and values. Regular meetings took place to monitor performance against objectives. Key risks to the services were recorded and managed through the use of local and corporate level risk registers.

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

- The service did not have a registered manager in place at the time of our inspection. It is a condition of the provider's registration that there is a registered manager in place. There had been no registered manager since March 2014. This is a breach of the condition of the provider's registration.
- Reported concerns such as recorded patient complaints, an unplanned return to theatre and an unplanned patient readmission had not been formally reported as incidents.
- This meant that although these concerns had been reviewed and appropriately resolved by staff, there was no standardised process for identifying and monitoring incidents in one place, which may help to identify themes or patterns.
- Patients were seated in close proximity to each other in their surgical gowns in the theatres area wait room. We saw that staff were present nearby however this arrangement may impact on patients' privacy and dignity.

Summary of findings

- The service did not carry out routine infection control audits. The service received the minutes from the host hospital's infection, prevention and control committee, however trust activities did not include weekends so these were not entirely representative.
- There were two registrars who had signed contracts with the service but we did not see any evidence to show appropriate recruitment checks had been carried out, such as General Medical Council (GMC) registration status, appraisal records or Disclosure and Barring Service (DBS).

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

Ellen Armistead

Deputy Chief Inspector of Hospitals (North Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. We rated this service as good because it was safe, effective, caring, responsive to people's needs and well-led.

Summary of findings

Contents

Good

Manchester Surgical Services

Services we looked at
Surgery

Summary of this inspection

Background to Manchester Surgical Services

Manchester Surgical Services opened in 2009. It is an independent provider of NHS care established at Trafford Hospital, a division of Central Manchester University Hospitals NHS Trust. The service primarily serves the communities of East Cheshire, Trafford and Stockport. It also accepts patient referrals from outside this area.

Manchester Surgical Services works in a collaborative partnership with Trafford General Hospital, who are the facility provider for their clinical pathways. The Manchester Surgical Services core team of staff consists of five administrative staff, the clinical nurse lead, the service manager and the head of operations. The core team are directly employed by the service and are primarily based at Trafford General Hospital.

Manchester Surgical Services does not directly employ any of its own clinical staff, with the exception of the clinic lead nurse who is directly employed by MSS. All other nursing and medical staff involved in patient care and treatment are employed under casual worker contracts or through practicing privileges. The clinical staff are mainly sourced from Trafford General Hospital, who also provide the premises, equipment and facilities for patients admitted under the care of Manchester Surgical Services.

Manchester Surgical Services provides a range of elective specialty services for patients over 18 years old. The core specialties offered by the service include:

- Orthopaedic clinics and surgical procedures for shoulders, hip and knee, hand and wrist and foot and ankle services
- Ear, nose and throat (ENT) surgery
- General Surgery
- Endoscopy

Surgery is the main service provided by Manchester Surgical Services. The service also provides a number of outpatient clinics from Trafford General Hospital and across three GP practices in Trafford and East Cheshire areas.

The outpatient activities mostly relate to initial consultations and post-operative follow ups for patients requiring surgery. Therefore we have reported the outpatient activities as part of the surgery core service.

Diagnostic imaging services are provided by an external independent healthcare provider under a service level agreement.

Manchester Surgical Services was previously inspected in January 2014. We found that the service was meeting all standards of quality and safety it was inspected against during that inspection.

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury

The service did not have a registered manager in place at the time of our inspection. The head of operations was appointed in October 2016 and was in the process of applying to become the registered manager for the service.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector, and a specialist advisor with expertise in theatre nursing.

The inspection team was overseen by Ann Ford, Head of Hospital Inspection.

Summary of this inspection

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 2 and 4 March 2017, along with an unannounced visit to the service on 17 March 2017.

As part of the inspection, we visited the outpatient, day case, endoscopy and theatre areas at Trafford General Hospital and an outpatient clinic at Priorsleigh Medical Centre.

We spoke with 19 staff including; registered nurses, a nursing assistant, a physiotherapist, administrative staff, the service manager, the clinical nurse lead, the head of operations, consultants, an anaesthetist and the clinical director of services. We spoke with 12 patients and the relative of a patient. We also received 12 'tell us about your care' comment cards which patients and their relatives had completed prior to our inspection. During our inspection, we reviewed 10 sets of patient records.

Information about Manchester Surgical Services

Manchester Surgical Services is an independent healthcare provider based at Trafford General Hospital within Trafford Healthcare NHS Trust in Trafford, West Manchester. The service operates in a collaborative partnership with Trafford General Hospital, who are the facility provider for their clinical pathways.

The service has the use of four operating theatres (including two laminar flow orthopaedic theatres), an endoscopy treatment room and outpatient clinic facilities at Trafford General Hospital.

The service also has access to an orthopaedic day case unit (with 20 day case beds), a general surgical day case unit (with 20 day case beds) and the orthopaedic ward (with beds) when required, and x-ray, outpatient and diagnostic facilities.

During 2016, there were 2,199 new patient appointments and 2,749 follow up appointments. There were 524 day cases and four inpatient admissions during this period. There were 1,320 visits to theatre during 2016. The majority of visits were for endoscopy (64%), followed by orthopaedics (19%), ear, nose and throat (ENT) (13%) and general surgery (4%).

Surgical procedures were only carried out on weekends and exclusively at the Trafford General Hospital. Approximately 80% of orthopaedic, ENT and general surgery procedures took place on Saturdays.

Endoscopy procedures were carried out during weekday evenings as well as on weekends. 40% of endoscopy procedures took place on weekday evenings, with 24% on Saturdays and 34% on Sundays.

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

We rated safe as 'Good' because:

- There were four incidents reported by the service between January 2016 and December 2017. These were all graded as "no harm". Incidents were investigated and actions were implemented to minimise the risks to patient safety. Information about incidents was shared with staff to aid learning.
- Care and treatment was delivered by staff working under casual worker arrangements and consultants under practicing privileges. The staffing levels and skills mix was sufficient to meet patients' needs. Most staff had completed mandatory training and safeguarding training.
- There were no serious patient safety incidents (such as patient falls, catheter urinary tract infections or pressure ulcers) reported between January 2016 and December 2016.
- There were no surgical site infections or cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia, Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, Clostridium difficile (C.diff) or Escherichia coli (E. coli) reported by the service between January 2016 and December 2016.
- Staff followed the host hospital's policies and procedures relating to medicines management, infection control and maintenance of the environment and equipment.
- Patients received care in visibly clean and appropriately maintained premises. Suitable equipment was available to support patients. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately.
- Staff assessed and responded to patients' risks and used an early warning score system. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist.

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

Summary of this inspection

- Staff had access to policies and procedures that provided information on incident reporting, investigation and learning. Reported concerns such as patient complaints, an unplanned return to theatre and an unplanned patient readmission had not been formally reported as incidents.
- This meant that although these concerns had been reviewed and appropriately resolved by staff, there was no standardised process for identifying and monitoring incidents in one place, which may help to identify themes or patterns.
- There was no specific audit in place to monitor staff adherence to the WHO checklist. The service planned to implement a WHO checklist audit from April 2017 onwards.
- The service did not carry out routine infection control audits. The service received the minutes from the host hospital's infection, prevention and control committee, however trust activities did not include weekends so these were not entirely representative.

Are services effective?

Good

We rated effective as 'Good' because:

- Patients received care according to national guidelines such as National Institute for Health and Care Excellence (NICE) and guidance from the Royal Colleges. Effective care and treatment was provided through the use of standardised patient care pathways.
- The service did not participate in any local or national clinical audits. However, patient outcomes were measured through feedback from patients and the routine monitoring of key processes.
- Care and treatment was provided by suitably trained, competent staff who worked well as part of a multidisciplinary team. All the core staff had completed their appraisals.
- Staff working under casual worker contracts and practicing privileges underwent recruitment checks and induction before they delivered care and treatment. There were no consultants with any outstanding queries relating to their practising privileges, appraisals or revalidations.
- Staff were aware of how to seek consent from patients prior to delivering care and treatment and understood what actions to take if a patient lacked the capacity to make their own decisions.

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

- There were two registrars who had signed contracts with the service but we did not see any evidence to show appropriate

recruitment checks such as General Medical Council (GMC) registration status, appraisal records or Disclosure and Barring Service (DBS) checks had been carried out. These members of staff never worked on an unsupervised basis.

Are services caring?

Good

We rated caring as 'Good' because:

- We spoke with 12 patients and a patient's relative across the outpatient clinics, endoscopy and theatre areas. They all spoke positively about the care they received. They told us the staff were kind and caring and their privacy was respected.
- The patient satisfaction survey from October to December 2016 received feedback from 72 patients and 91% of patients who responded were either likely, or extremely likely to recommend the service to family and friends.
- Patients and their relatives were kept fully involved in their care and the staff supported them with their emotional and spiritual needs.

Are services responsive?

Good

We rated responsive as 'Good' because:

- Services were planned and delivered to meet the needs of patients. Most services were delivered at the host hospital. Outpatient clinics were also in place across three GP practices in Trafford and East Cheshire areas.
- Services were provided for adult elective patients and staff were able to plan for the patient in advance so they did not experience delays in their treatment. There was daily planning and effective communication so patients could be admitted, treated and discharged in a timely manner.
- The majority of patients received treatment within 18 weeks of referral and waited less than 6 weeks from referral for a diagnostic test. The service monitored performance against waiting time targets to reduce delays in treatment.
- There were only four operations cancelled for non-clinical reasons between April 2016 and December 2016. All the patients were treated within 28 days of the cancellation date.
- There had been no new or follow up appointments cancelled by the service within two weeks of the appointment date between April 2016 and December 2016. Discharge summaries were consistently issued to patients' GPs within specified timelines.
- There were systems in place to support vulnerable patients such as patients living with dementia or a learning disability.

Summary of this inspection

- Patients understood how to make a complaint or raise a concern. Complaints about the services were resolved in a timely manner and information was shared with staff to aid learning.

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

- Patients were seated in close proximity to each other in their surgical gowns in the theatres area waiting room. We saw that staff were present nearby, however this arrangement may impact on patients' privacy and dignity.

Are services well-led?

Requires improvement

We rated well-led as 'Requires Improvement' because:

- The service did not have a registered manager in place at the time of our inspection. It is a condition of the provider's registration that there is a registered manager in place. There had been no registered manager since March 2014. This is a breach of the condition of the provider's registration.

However, we also found that:

- The service had a clearly defined vision and values and these had been shared with staff. Staff were positive about the culture within the service and the support they received from their management team.
- Key risks to the services were recorded and managed through the use of local and corporate level risk registers. There were regular staff meetings to monitor performance against objectives.
- Senior management team meetings and medical advisory committee (MAC) meetings took place every three months. The service also commenced joint clinical effectiveness meetings with the host site (Trafford General Hospital) in February 2017.
- Staff were positive about the culture within the service and the level of support they received from their management team.

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	Requires improvement	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as Good.

Incidents

- There were no 'never events' reported by the service between January 2016 and December 2016. 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.
- There had been four incidents reported between January 2016 and December 2016. All were graded as 'no harm'. Two of the incidents related to theatre documentation issues and were reported on the same day in April 2016.
- The other two incidents related to complications following treatment; one resulted in an unplanned overnight stay and the other resulted in a review by the on-site hospital staff in line with the service level agreement between the two organisations.
- We reviewed the records for all four incidents. These included clear summaries of what had happened at the time, what investigations had taken place and what actions had been implemented to minimise the chance of a recurrence.
- All staff we spoke with were aware of the process for reporting any identified risks to staff, patients and visitors. Incidents were reported using the electronic reporting system provided by the host hospital, as set out in the service level agreement. The Manchester Surgical Services (MSS) staff had access to this system.
- The terms of the service level agreement with the host trust specified that the trust was responsible for reporting and managing incidents relating to the patients that had been referred to MSS from the host trust.
- The host trust took ownership for managing these incidents but there was collaboration between the two organisations and the MSS clinical nurse lead provided input into incident investigations when required.
- The head of operations told us they relied on the trust to inform them of incidents that had been reported by the host trust but this was not always communicated to them in a timely manner. For example, a recent incident for a patient that had been treated by the host hospital had been investigated by their staff and the outcome and details of remedial actions had not been shared with MSS.
- The incident reporting system did not have a separate category to identify incidents specifically relating to MSS. This meant the service was reliant on any MSS incidents being identified by the manager of the hospital area where the incident was reported.
- The head of operations told us they were in discussions with the host hospital to identify a simpler way to identify MSS incidents reported on the host hospital's incident reporting system, such as an 'MSS' field. This would mean incidents relating to this service could be easily identified to facilitate reporting.

- The head of operations had also introduced a paper based incident form for staff to record incident details, in order to ensure all reported incidents were identified. This was in addition to the electronic system.
- The MSS incident policy defined an incident as any event or circumstances involving patients, visitors or staff that could have or did lead to unintended or unexpected harm, loss or damage. However, we found that not all such events or circumstances were being formally reported as incidents on the electronic reporting system.
- For example, an unplanned patient return to theatre in August 2016 and an unplanned patient readmission via accident and emergency (A & E) during September 2016 had not been formally reported as incidents.
- We also found examples in the concerns, causes and countermeasure ("3C's") log sheet of situations that met the criteria to be reported as incidents. For example, a concern was raised where a consultant saw an 'extra' patient in clinic (without a referral record). We saw that remedial actions were taken to address this issue (such as discussions with the consultant about future practice) but this had not been formally reported as an incident.
- This meant that although each event had been discussed and appropriately resolved by staff, there was not a way of identifying and monitoring incidents in one place, which may help to identify themes or patterns.
- Learning from incidents was discussed at a daily huddle attended by the core MSS team. We saw documented evidence of this. The clinical nurse lead was responsible for communicating any actions and learning to the clinical staff, either in person or via email where necessary. Incidents were also discussed at team meetings and senior management meetings.
- There was a duty of candour policy in place and although there had been no serious incidents we saw evidence that the service was open and transparent with patients when things had gone wrong.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- There had been no patient deaths reported in relation to the service between January 2016 and December 2016. The clinical director told us that any patient deaths would be reviewed by the medical advisory committee, which held meetings every three months.

Clinical Quality Dashboard or equivalent

- There were no serious patient safety incidents (such as patient falls, catheter urinary tract infections or pressure ulcers) reported between January 2016 and December 2016.
- The service reported that it had carried out venous thromboembolism (VTE) risk assessments for 100% of its patients between April 2016 and December 2016. There had been no cases of healthcare-acquired VTE or pulmonary embolism (PE) reported by the service during this period.
- The service did not have a clinical quality dashboard in place to monitor patient safety. All patient safety incidents were logged on a spreadsheet and reviewed by the management team at least monthly to look for improvements to the service.

Cleanliness, infection control and hygiene

- There were no cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia, Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, Clostridium difficile (C.diff) or Escherichia coli (E. coli) reported by the service between January 2016 and December 2016.
- There were no surgical site infections (SSIs) reported between January 2016 and December 2016.
- All patients underwent MRSA screening prior to undergoing orthopaedic hip and knee replacement surgery.
- The host hospital was responsible for maintaining the cleanliness of the environment and equipment. We saw that staff followed the host hospital's policies for cleaning the environment and cleaning and decontaminating equipment and for the handling, storage and disposal of clinical waste, including sharps.
- The clinic rooms, day case ward, endoscopy and theatre areas we inspected were visibly clean and tidy. We saw that daily cleaning checklists were in place and completed by staff.
- There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below

the elbow' guidance. Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre area.

- Hand hygiene audits took place every three months. The hand hygiene audit for October to December 2016 sampled 20 staff in the outpatient clinic areas and showed 100% staff compliance.
- Hand hygiene audits were not carried out in the theatre areas. The clinical nurse lead confirmed these would be incorporated into the next hand hygiene audit. All the day case ward and theatre staff we observed during the inspection demonstrated good adherence with hand hygiene guidelines.
- The service did not carry out routine infection control audits. The service received the minutes from the host hospital's infection, prevention and control committee, however trust activities did not include weekends so these were not entirely representative. We reviewed the minutes from December 2016 but the items under discussion did not concern areas of the host hospital used by the service.

Environment and equipment

- The clinics, endoscopy and theatre areas we visited were well maintained, free from clutter and provided a suitable environment for treating patients.
- All clinical activities were provided from services managed by the host hospital or in clinic rooms based in General Practitioner (GP) practices. The service level agreement with the host trust allowed the service access to the day case wards, four operating theatres, the outpatient clinic areas and one endoscopy treatment room.
- The host organisation was responsible for maintaining equipment and ensuring its availability. The service planned to seek assurance that equipment was suitable for use with their patients through the monthly joint clinical effectiveness meeting.
- The clinical nurse lead had access to an equipment servicing log from the host hospital. If staff had concerns relating to equipment they could access the log to check service status and availability of equipment in the clinical areas.
- Equipment was appropriately checked and cleaned regularly. All the equipment we saw had service stickers displayed and these were within date. Single-use, sterile instruments were stored appropriately and were within their expiry dates.
- Reusable surgical instruments were sterilised in the host hospital's sterilisation facilities and staff told us they did not have any concerns relating to the sterilisation or availability of surgical instruments.
- Reusable endoscopes (used to look inside a body cavity or organ) were cleaned and decontaminated in a dedicated decontamination room. The facility was accredited by the joint advisory group for gastrointestinal endoscopy (JAG).
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff. However, we saw that daily logs for anaesthetic machines in the theatres were not always completed. The head of operations told us they would discuss this with the host hospital through the monthly joint clinical effectiveness meeting.
- There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff and responded to in a timely manner.

Medicines

- There were no medicines prescribed during outpatient clinics that took place in satellite locations, such as in GP practices. If a patient required prescribed medication, the consultants completed a non-urgent advice note to the patient's GP.
- The service had a policy in place for the ordering, storage and prescribing of six specified medication items (such as pain numbing creams and disposable enema kits). These were used during outpatient clinics that took place at the host hospital. The service had an arrangement with a local pharmacy to supply these medicines and staff had clear instructions on how to record when these items were used for patients visiting the clinics.
- Staff followed the host hospital's processes for ordering, storing, handling, prescribing and discarding medicines used during surgery. We found that medicines, including controlled drugs, were ordered, stored and discarded safely and appropriately.

- The patient records we looked at showed that surgical patients were given their medicines in a timely way, as prescribed, and records were completed appropriately.
- Medication records generated over the weekends were reviewed by the hospital pharmacists on Mondays via an electronic system. In most cases patients were sent home with 'over the counter' pain relief.
- Links with the host hospital's pharmacy team will be further strengthened by the scheduled attendance of the hospital deputy director of pharmacy at the monthly joint clinical effectiveness meetings.

Records

- The service used paper based patient records and these were securely stored in each area we inspected.
- We looked at the records for 10 patients. All of the records were well structured, legible and up to date.
- Patient records included information such as consent records, medical history reviews and pre-operative assessment records. The records showed that nursing and clinical assessments were carried out before, during and after surgery and these were documented correctly.
- Patient records included appropriate risk assessments for situations such as moving and handling, patient falls, venous thromboembolism (VTE – blood clots), pressure care and nutrition and they were completed correctly.
- Staff prepared an outpatient clinic file before each clinic. This included the records for each patient due to attend the clinic. The records included patient history, investigation / test results, referral letters (such as from the GP) and any previous clinic consultation letters.
- The clinical nurse lead carried out a clinical records audit every three months. The audit sampled 5% of patient records, divided between specialties. The audit covered key standards relating to documented records for admission, clinical content, consent, procedure details, health records and discharge details.
- We reviewed four records audit reports from 2016 and these showed there was a good standard of documentation recorded. The audits showed that 100% compliance was achieved in most cases. Where omissions were identified it was noted that these had been discussed with individual staff to aid their learning. The audit reports were also reviewed by the medical advisory committee (MAC).

Safeguarding

- Staff received training in the safeguarding of adults and children. The service did not provide care and treatment for patients under 18 years of age.
- Records showed the administrative and non-clinical core MSS staff had completed level one safeguarding training. The clinical nurse lead was the safeguarding lead for the service and had completed safeguarding level two training.
- Records showed the majority (77%) of the clinical staff used by the service (bank and host hospital staff) had also completed safeguarding level two training.
- The staff we spoke with were aware of how to identify potential abuse and report safeguarding concerns. Information on how to report safeguarding concerns within the organisation and externally (e.g. to the local authority) was clearly displayed in the areas we inspected.
- There had been no safeguarding incidents reported by the service between January 2016 and December 2016.

Mandatory training

- The service level agreement with the host trust set out that MSS were responsible for ensuring their own staff were appropriately trained. Records showed 100% of the core MSS staff had completed the host trust's corporate mandatory training and information governance training.
- The clinical nurse lead carried out checks to confirm that staff contracted to work within the service from the host hospital or nursing bank had completed their mandatory training.
- The clinical nurse lead was able to access the host trust's training database to review any changes to this. We saw evidence that the majority of the contracted staff had completed their mandatory training.
- We also reviewed three staff records and all had evidence of up to date corporate mandatory training including fire safety, manual handling, safeguarding, information governance, risk management and infection prevention and control.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- Prior to undergoing surgery, staff carried out pre-operative risk assessments to identify patients at risk of harm. Patients were also assessed by an anaesthetist and surgeon on the day of surgery to determine if they were suitable to undergo surgery.

- Patients with complex medical conditions, such as patients with cancer or chronic pain symptoms were excluded from receiving treatment at the service.
- The service only admitted patients undergoing elective surgery. The majority of patients admitted to the hospital had an American Society of Anesthesiologists (ASA) physical status score one or two, i.e. patients who were generally healthy or suffered from mild systemic disease.
- As part of the pre-operative assessment process, patients with certain medical conditions were referred for consultant or anaesthetist review to determine whether they could undergo surgery. This included patients who had previously had a blood transfusion, patients with an oxygen saturation level of less than 92% or patients with a body mass index greater than 40.
- There was an early warning score (EWS) system in place, to identify if a patient's medical condition was deteriorating. EWS is a system which 'scores' patients based on their observations readings such as temperature, blood pressure, pulse, consciousness level.
- There were clear instructions for staff on actions to take when patients' EWS scores increased, however there were no instances where this had occurred during the past 12 months.
- Staff followed clinical pathways for the recognition, diagnosis and management of sepsis. There were no instances where patients receiving treatment had acquired sepsis during the past 12 months.
- If a patient's condition deteriorated, procedures were in place for stabilising and managing their condition. There was a flow chart in place for unexpected admissions and a 'failed day case' pathway with algorithms to direct clinicians if escalation was necessary.
- Deteriorating patients could be escalated to the host hospital's high dependency unit (HDU), with responsibility for care of the patient transferring to the host hospital. Patients who required intensive care support would be transferred in line with the host hospital's policy, to a facility able to provide the required level of care.
- The service reported that there were no transfers of surgical patients to other hospitals between January 2016 and December 2016.
- There was one reported instance of an unplanned return to theatre following surgery during this period (due to post-operative bleeding). The patient was kept on the surgical inpatient ward overnight following treatment and was discharged the following day.
- We observed five theatre teams undertake the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- We also observed one endoscopy team undertake the safer endoscopy checklist and staff demonstrated good adherence before, during and after the endoscopy procedure.
- We looked at the records for five patients who had undergone surgery during the inspection and the WHO checklists were completed appropriately in each case.
- There was no specific audit in place to monitor staff adherence to the WHO checklist. The clinical nurse lead had developed a WHO audit proforma and an audit of 10% of all records was scheduled to take place every three months from April 2017 onwards.

Nursing and support staffing

- The service did not directly employ their own nursing, theatre or support staff. Staff from the host hospital were recruited on a casual worker contract to provide patient care and treatment. Staff contracted by the service only worked in the same nursing or theatre role they carried out during their routine employment at the hospital.
- Information provided by the service showed there were approximately 162 contracted staff across a range of nursing, theatre, support and administrative roles. Staff were enthusiastic about their roles and the clinical nurse lead told us they were able to maintain suitable staffing levels because of the large staff pool they could access.
- There was a core MSS team consisting of five administrative staff, the clinical nurse lead, the service manager and the head of operations. These staff worked only for MSS. There were no vacancies within the core MSS team.
- The clinical nurse lead worked 24 hours per week during weekdays and had overall responsibility for clinical

activities. There was a heavy reliance on the clinical nurse lead who would be available even outside of working hours or while on leave, in case they were needed.
- When the clinical nurse lead was not available or on leave, a hospital nurse was asked to take the clinical nurse lead role, with some support from the service manager and head of operations. There was a plan to recruit an additional band 6 nurse to support the clinical nurse lead and provide cover during leave. The post was due to be advertised by the end of March 2017.
- The clinical nurse lead was responsible for staffing the outpatient clinics. Staff rotas were completed two to three weeks in advance of the clinics to ensure there was sufficient staffing. The outpatient clinics were staffed with at least one nurse per consultant.
- The outpatient clinics at the host hospital were also staffed with a receptionist when needed. The community outpatient clinics took place in GP practices where the reception duties were carried out by reception staff based at the practice.
- The day case ward was staffed by two qualified nurses if there was one theatre list and an additional healthcare assistant if there were more than ten patients. If there was more than one theatre list an additional qualified nurse was put in to maintain suitable staffing levels.
- Endoscopy cover was provided by one receptionist, one member of staff in decontamination, one qualified nurse admitting the patient, two qualified nurses in the procedure room and the admitting nurse would move into the patient recovery area when necessary.
- The theatre areas had sufficient numbers of trained nursing and support staff with an appropriate skill mix. The theatre staffing levels were based on nationally recognised guidelines such as the Association for Perioperative Practice (AfPP).
- The host hospital managed their own staff sickness and where staff had been absent from work through sickness they were not permitted to do additional work for MSS.

Medical staffing

- The service did not employ any substantive medical staff. Medical cover was provided by approximately 46 consultants and anaesthetists who were mainly employed by the host hospital in substantive posts and had practising privileges (the right to practice in a hospital) with the service.
- Under their practicing privileges contract, consultants and anaesthetists were required to provide care to the patient either by being present in the hospital, or on-call over 24-hours until that patient was discharged from hospital.
- Staff in each clinical area had a list of contacts for all the consultants and anaesthetists for each patient so they could be contacted when needed.

Emergency awareness and training

- The business continuity strategy and plan 2016-2018 detailed the arrangements made with the host hospital should an event occur which threatened to disrupt the activity of the service. The core team were familiar with this plan, and knew where to find it.
- Instructions for staff to follow in the event of a fire or medical emergency were in place.

Are surgery services effective?

Good

We rated effective as Good.

Evidence-based care and treatment

- Patients received care according to national guidelines such as the National Institute for Health and Care Excellence (NICE) and guidance from the Royal Colleges.
- Staff used the host hospital's policies and care pathways for endoscopy, elective orthopaedic and general surgery, day case and elective surgery under local anaesthetic. This meant the staff involved in patient care were familiar with these and understood how to follow these pathways effectively.
- Where the service had developed its own clinical policies and procedures, these were reviewed and ratified by the medical advisory committee (MAC) to check they complied with relevant national guidelines (such as NICE). The services planned to present these at future joint clinical effectiveness meetings.

Pain relief

- If a patient attending an outpatient clinic experienced pain due to their medical condition, this would be

discussed as part of their consultation. Patients awaiting orthopaedic surgery were given analgesic pain injections by the consultant if they experienced severe pain symptoms.
- Patients with chronic pain symptoms were not routinely admitted for surgical treatment by the service.
- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals post-operatively.
- The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort.
- Patients told us staff gave them pain relief medication when needed and their pain symptoms were managed appropriately following their procedure.

Nutrition and hydration

- Patients were given advice and written information around fasting in preparation for surgical procedures. This included advice on when they should stop eating and drinking, and was dependent upon their procedure.
- Patient records included assessments of patients' nutritional requirements. Staff assessed patients using the malnutrition universal screening tool (MUST).
- All patients were admitted for day case procedures and staff provided refreshments and a light meal (such as a sandwich) following their procedure.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered to them following their procedure.

Patient outcomes

- The service primarily monitored patient outcomes through feedback from the patients. Patient satisfaction surveys demonstrated that the majority of patients experienced positive outcomes following surgery at the hospital.
- The service only undertook four hip and knee replacement procedures between January 2016 and December 2016. The implants were provided by the host trust. These patients were reported in the national joint registry through the host hospital.
- Patient reported outcome measures (PROMs) measure health gain in patients undergoing certain types of surgery in England, based on responses to questionnaires before and after surgery. For the 2015-2016 period MSS had no eligible patients. In 2016-2017 four patients completed the pre-operative questionnaire; however no follow-up had yet been undertaken.
- There had only been four hip and knee surgery replacement procedures between January 2016 and December 2016. This meant comparable data could not be obtained as the number of patients who underwent these procedures at the service was statistically insignificant.
- The service collated and sent monthly key performance indicator (KPI) data to the clinical commissioning group (CCG) as part of the commissioning for quality and innovations (CQUINs) between April 2016 and March 2017.
- The data included targets for 19 quality indicators such as patient safety performance, referral to treatment times, number of cancelled operations and time scales for discharge summaries to be issued to GPs. Records showed 94% of the specified targets had been achieved by the service between April 2016 and December 2016.
- The KPI performance demonstrated that the majority of patients experienced the expected standard of care and treatment.
- The service reported that between January 2016 and December 2016 there had been one unplanned return to theatre and one unplanned re-admission via accident and emergency at another hospital. These cases were discussed at the MAC meeting in October 2016 and minuted accordingly. Both patients made a full recovery and no issues with their care were identified. All other KPIs had been met.

Competent staff

- Newly appointed core MSS staff underwent an induction process and their competency was assessed prior to working unsupervised. Staff recruited on casual worker contracts also underwent an induction with the clinical nurse lead.
- The core MSS staff had completed their appraisals. The head of operations confirmed that when they had joined the service in October 2016 the appraisals for the five administrative staff were due but these had been completed recently.
- The appraisal records had been reviewed by the head of operations who completed them with the director of operations. The head of operations recognised that the

appraisal process needed to be more formal and plans were in place to review appraisals every six months. The head of operations was training the service manager to appraise the administrative staff.

- We reviewed three MSS staff records. All had completed performance and development records in place.
- The staff recruited on casual worker contracts received their appraisals through their main employer and this was checked by the clinical nurse lead when they first commenced employment. Informal discussions would take place with the clinical lead nurse if a member of staff wanted to develop within MSS.
- We looked at the recruitment files for four staff who worked on a casual worker contract. These showed appropriate checks were carried out prior to their recruitment, including Disclosure and Barring Service (DBS) checks, personal identification, proof of qualifications, registrations with approved bodies and evidence of inoculations (such as for Hepatitis B).
- Consultants working at the hospital were employed under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital). All of the consultants had substantive posts either within the NHS or another independent health organisation. This meant that their General Medical Council (GMC) revalidation and appraisals were managed by their primary employer.
- The clinical director of services told us the practising privileges process was last reviewed by the management team approximately two years ago. There was no formal cycle to review these on a periodic basis.
- We reviewed six consultants' personnel files. All had evidence of the expected recruitment checks in place. We also spoke with three consultants during the inspection. They confirmed their practicing privileges had been reviewed and they had submitted information such as appraisal records, GMC revalidation, indemnity certificates and DBS checks when they first started to work for the service.
- The service reported there were no consultants with any outstanding queries relating to their practising privileges, appraisals or revalidations.
- There was a handbook provided to each MSS consultant that included details of the escalation pathway for deteriorating patients, along with safeguarding information and details about incident reporting.
- The clinical director of operations told us some consultants preferred to be accompanied by a registrar (as a surgical first assist practitioner) when carrying out surgical procedures. The service manager and head of operations confirmed there were two registrars contracted with the service at the time of our inspection.
- We did not see evidence to show the sufficient recruitment checks had been carried out for these two registrars. The head of operations told us they had requested information such as GMC registration status, appraisal records and DBS checks for the two registrars following our inspection.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the clinics, day case wards and endoscopy and theatre areas. The clinical lead nurse liaised with the theatres, endoscopy and outpatient clinic staff on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- The staff employed on casual worker contracts told us they had a good relationship with the clinical lead nurse. Most of the staff worked within the same teams as part of substantive roles within the host hospital, which facilitated good team working between the nurses and consultants.
- Specialty multidisciplinary (MDT) meetings took place on a weekly basis within the host hospital and any MSS patient concerns were discussed during these meetings.
- There were routine meetings that took place within the service and monthly joint clinical effectiveness meetings involving representatives from the service and the host hospital.
- Physiotherapy and occupational therapy support was provided by the host trust, as were other services such as pharmacy, pathology and histology support.
- The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals.
- The service had an agreement in place with an external independent health provider for diagnostic support, such as computerised tomography (CT), magnetic resonance imaging (MRI) and ultrasound scans for patients as part of their pre-operative assessment.

- The service level agreement between the service and the host trust had been signed in January 2017 and was due to be renewed on an annual basis, with a six monthly review.

Access to information

- At off site outpatient clinics the patient history record was sent with the appointment list to the location. The files were transported by a member of staff before each clinic in a tamper-proof case to ensure security.
- There was a feedback form completed after every clinic and sent back to the core team to provide an update on activity within the clinics.
- The service used paper records and they also had an electronic patient administration system (PAS) which was updated by information transferred across automatically from choose and book.
- Clinic letters from outpatient appointments, consultation summaries and appointment letters were generated on the electronic PAS system so they could be accessed electronically.
- Discharge letters were scanned and put on to the hospital's PAS system which could also be accessed by the MSS staff. MSS staff also had access to the host hospital's incident reporting system, policies and procedures, staff training system and equipment maintenance systems.
- There were no instances reported by the service where records were unavailable for patients attending outpatient clinics between January 2016 and December 2016.
- All patient records and clinical notes were stored securely in the service's main office until a patient was discharged. Following patient discharge, the patient records were uploaded onto the host trust's e-record system where they could be accessed electronically if needed.
- There was a backlog with the host trust, with notes from 2015 waiting to be scanned. There was a tracking system so that paper-based patient records could still be retrieved from the host trust's scanning department if required. However, the back log issue had not been identified as a risk on the service's risk register.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Consent for surgery was first discussed and recorded at the patient's outpatient department pre-operative assessment appointment. This was in line with the host hospital's consent policies.
- The clinical records audit for October to December 2016 was based on a sample of 15 patient records. The audit showed written consent was obtained during outpatient consultations on 86% of occasions and on the day of surgery on 14% of occasions during this period. This was attributed to the practice of an individual consultant and the clinical nurse lead provided evidence that action was being taken to address this.
- Patient records showed that written and verbal consent had been obtained from patients and that planned care was delivered with their agreement. Consent forms showed the risks and benefits were discussed with the patient prior to carrying out a surgical procedure.
- Patients who lacked capacity were identified during their pre-operative assessment in order to determine whether they could be admitted for treatment. Where patients lacked the capacity to provide informed consent, staff told us they made best interest decisions and involved the patient's representatives and other healthcare professionals, such as the patient's general practitioner (GP).

Are surgery services caring?

Good

We rated caring as Good

Compassionate care

- Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
- We spoke with 12 patients and the relative of a patient across the outpatient clinics, endoscopy and theatre areas. All the patients said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their

dignity was maintained. The comments received included: "staff were helpful, really happy with the service" and "staff were reassuring and explained everything".

- The service carried out patient satisfaction results every three months. During October 2016 and December 2016, 212 questionnaires were sent out and 72 (34%) were returned.
- The survey results showed that patients were very satisfied with the management of their referrals, communication with the consultant, and involvement with their care and treatment. 91% of patients that responded were either likely, or extremely likely to recommend the service to family and friends.
- The head of operations told us they were pleased with the feedback but felt they could improve further and had set a target for 95% of patients to recommend the service to family and friends.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- Patient records included pre-operative assessments that took into account individual patient preferences.
- Patients told us they were kept informed about their treatment and the consultants and anaesthetists were clear at explaining their treatment to them. This allowed them to make informed decisions about their care and treatment.
- Patients also spoke positively about the information they received prior to commencing treatment. They told us they received information that was specific to their treatment.

Emotional support

- Patients told us the staff were calm, reassuring and supportive and this helped them to relax prior to undergoing treatment.
- We observed the staff in the outpatient clinics, day case ward and theatres providing positive support and reassurance to a patient undergoing treatment during the inspection.
- During consultations patients were offered a chaperone (such as another member of staff) or patients were invited to have a friend or relative present.
- Counselling services were not provided by the service; however staff told us patients could be given information for counselling services through external organisations such as the host hospital, if needed.

Are surgery services responsive?

Good

We rated responsive as Good

Service planning and delivery to meet the needs of local people

- Patients' privacy and dignity were maintained in the majority of the areas we inspected. However, the theatres area had a small waiting room where two patients (one male and one female) waited for a short period of time before going into the operating theatre anaesthetic room. These patients were seated in close proximity to each other in their surgical gowns. We saw that staff were present nearby however this arrangement may impact on patients' privacy and dignity.
- We raised this with the head of operations during the inspection, who provided assurance that the impact to patients' privacy and dignity would be addressed.
- Services were planned and delivered to meet the needs of the local population. The service provided seven elective surgical specialties including hip and knee surgery, hand and wrist surgery, shoulder and foot and ankle surgery, general surgery, endoscopy and ear, nose and throat surgery.
- All surgical and endoscopy procedures took place at the host hospital as well as orthopaedic outpatient clinics. The service also delivered outpatient clinics across three GP practices in Trafford and East Cheshire areas.
- Patients had an initial outpatient consultation to determine whether they needed surgery, followed by a pre-operative assessment. Where a patient was identified as needing surgery, staff were able to plan for the patient in advance so they did not experience delays in their treatment when admitted to the service.

- There was daily communication between the clinical lead nurse and clinical staff in the outpatient clinics, endoscopy and theatre areas so that required resources (such as staff and equipment) could be arranged in advance.
- The services were only available to adults over 18 years old. The majority of patients were admitted for elective day case procedures. There was sufficient capacity to admit and treat these patients in a timely manner. The service had access to the host hospital's facilities, including four operating theatres, one endoscopy treatment room and access to the day case and outpatient clinic areas.
- The service had a standard NHS contract with the Trafford clinical commissioning group (CCG) and with East Cheshire CCG as co-commissioners until 31 March 2016. On 1 April 2016 East Cheshire CCG took over as lead commissioners. We spoke with both commissioning groups and neither raised any concerns about the service.

Access and flow

- Referrals were accepted from GPs and other local NHS providers as well as the host trust. All patients had access to the same level of treatment and arrangements as patients within the host hospital.
- There were three streams of referrals; e-referrals (choose and book) was the main point of referral but referrals by post or fax referrals, though minimal, were also accepted. Clinics were listed on the e-referral system 35 days ahead of their date.
- Reminders for outpatient appointments were generated by the patient administration system (PAS). Reminder phone calls were made to patients from the office for surgery and endoscopy 24 to 48 hours before the patients scheduled appointment.
- Patients that did not attend (DNA) their outpatient clinics were discharged back to their GP. If the patient contacted the service to cancel an appointment and wanted to re-arrange they would accommodate this on a discretionary basis.
- The service did not record patient DNA rates. Individual instances were recorded on the activity sheets completed by the clinics. The service manager told us the proportion of patients that not attend their outpatient clinics was low (approximately 1 - 2%) and they would take appropriate actions if an increase in DNA rates was identified.
- During the inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients from the clinics, endoscopy and theatre areas. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- The patient satisfaction survey for the period between October 2016 and December 2016 showed that 96% of respondents were satisfied with the length of time taken from their first consultation to having their procedure done. All comments had been reviewed and actions documented. Where patients responded negatively, the clinical lead nurse had contacted these patients to discuss their concerns.
- Staff completed a discharge checklist, which covered areas such as medication and communication to the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner. Discharge letters written by the consultants included all the relevant clinical information relating to the patients treatment or consultation.
- The service reported that 100% of discharge summaries were issued to the patient's GP within 24 hours of day case patients being discharged from the service between January 2016 and December 2016.
- During this period, the service also reported that 100% of discharge summaries were issued to the patient's GP within 5 working days of all outpatients discharged from the service, except during August 2016 where five outpatient discharge letters were delayed due to a problem with the digital dictation machine. The discharge letters were sent on the 6th working day.
- There were four operations cancelled for non-clinical reasons between April 2016 and December 2016. All these occurred on the same day in November 2016 following a surgical list cancellation. All the patients were treated within 28 days of the cancellation date.
- The service reported there had been no new or follow up appointments cancelled by the service within two weeks of the appointment date between April 2016 and December 2016.
- The service consistently achieved the 18 week referral to treatment (RTT) waiting time targets for non-admitted and incomplete pathway patients between April 2016 and December 2016. There were no patients that waited over 52 weeks for treatment during this period.
- The monthly percentage of admitted patients treated within 18 weeks of referral ranged between 83 - 94%,

compared with the internal target of 90%. Those not meeting the target had all been reviewed by the service and were mainly due to delays initiated by the patient or reasons beyond the control of the service.
- The monthly percentage of patients waiting less than 6 weeks from referral for a diagnostic test ranged between 90 - 100%, compared with the internal target of 99%. The breaches only accounted for a small number of patients (12) and were mainly due to patient choice or patients requiring both colonoscopy (test to look at the inner lining of large intestine) and a gastroscopy (to look inside the oesophagus) procedure.
- The majority of patients underwent elective day case procedures. There were only four instances where patients were admitted as inpatients between January 2016 and December 2016. These were all planned admissions for patients undergoing hip or knee replacement surgery. All four patients stayed at the host hospital over three nights and were discharged as normal with no complications.
- Where patients were admitted overnight, responsibility for their immediate care needs transferred to the hospital ward staff and junior doctors but remained under the overall care of the MSS consultant who could be contacted if needed.
- We looked at the records for one patient who was admitted for three nights following routine hip replacement surgery and they were reviewed daily by the ward based doctor.

Meeting people's individual needs

- Information leaflets about the services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, if requested.
- When a patient needed an interpreter this was identified on the referral by the GP and the service and staff regularly face to face interpreters. Alerts would also be flagged on the patient administration system which would be sent out the relevant clinic, for example if a patient was going for diagnostic tests at another location. The service had an arrangement with an interpreter service and staff were familiar with how to contact this service when needed.
- The pre-operative assessment identified patients living with dementia or a learning disability and this allowed the staff to decide whether they could accommodate the patients' needs. Staff followed a learning disabilities care pathway and staff were able to describe reasonable adjustments such as carrying out a planned procedure at the start or end of the list and allowing the patient to be accompanied by a carer.
- Staff also used the host hospital's 'passport' document for patients living with dementia or a learning disability. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes.
- Staff could contact the host hospital's safeguarding team for advice and support for dealing with patients living with dementia.
- The services were accessible for patients with mobility issues. When patients had additional needs, for example mobility problems, this was identified in clinic appointment prior to surgery and fed back to the relevant staff and the clinical nurse lead. At pre-operative assessment stage any special arrangements or specialist equipment (such as mattresses) that was required would be put in place.
- Staff provided examples of how they had responded to specific patient requests, in order to accommodate individual needs, such as flexible arrangements with family involvement where patients were experiencing particular anxiety. This meant patients were being given the opportunity to have a more positive experience.

Learning from complaints and concerns

- Information for patients and their representatives on how to raise complaints about the service was clearly displayed in all the areas we inspected.
- The MSS complaints policy stated that formal complaints would be acknowledged within 48 hours of receipt days and responded to within 25 working days.
- There were no formal complaints received in the reporting period between January 2016 and December 2016.
- There had been one written complaint received in February 2017. We reviewed the process that had been followed for this and found the complaint was dealt with promptly and all appropriate action was taken. The matter was investigated and resolved within three weeks, and the patient was happy with the outcome and had emailed their thanks to the service.
- There was a duty of candour policy in place. We saw evidence that the service promoted an open and transparent culture, and we saw an apology included in the letter sent out to the recent complainant.

Good

Surgery

- The core team maintained a "3cs" (concerns, cause and countermeasures) log which listed any received complaints (verbal or written) or comments from telephone calls or patient satisfaction questionnaires. The log summarised the concerns raised and the outcome of any remedial actions taken.
- Information about complaints was discussed during daily huddle meetings to raise staff awareness and aid future learning.

Are surgery services well-led?

Requires improvement

We rated well-led as Requires Improvement

Leadership / culture of service related to this core service

- The service did not have a registered manager in place at the time of our inspection. It is a condition of the provider's registration that there is a registered manager in place. There had been no registered manager since March 2014. This is a breach of the condition of the provider's registration.
- The head of operations was appointed in October 2016 and was in the process of applying to become the registered manager for the service.
- At MSS there was a head of operations leading the service who started in October 2016, supported by a service manager and a clinical nurse lead. The clinical nurse lead was the main link between the clinical staff and the managers. They were well known and well regarded throughout the service which was somewhat reliant on their knowledge of the staff and the hospital, built up through many years working originally for the host NHS trust, and subsequently for MSS.
- It was evident that since the head of operations had joined the service they had been making regular and fast moving improvements to systems and processes. The team were receptive to change and keen to be the best they could be. The managers were open with us when we met with them, and enthusiastic about sharing with us their plans for further improvements. By the end of our inspection they had already put in place plans to address some of the issues that had arisen, for example incident reporting was scheduled as an agenda item at the April 2017 MAC meeting.
- There was a clinical director of services who was also a consultant with the host hospital. The clinical director was contracted to attend the service's site management meetings and was also the chair of the medical advisory committee.
- MSS had two sister organisations, but they were three individual companies, managed as three separate businesses. Corporate policies were adapted to meet the needs of the local organisations; however most policies in use were those of the host NHS trust.
- Managers referred to the Tyneside organisation as 'head office', however they told us this was an informal term used mainly because the board of directors was based there. The executive company director was also the finance director and they made the decisions around capital purchases, salary increases and other very senior management concerns such as setting the fee structure with partner organisations.
- Managers told us they were able to speak with the executive director whenever they needed to, that they returned calls and emails in a timely manner, and visited their location every three months. When they attended senior management meetings, met the staff in the office and asked them for their views, for example about a new branding that was in progress.
- All the staff we spoke with were highly motivated and positive about their work. Staff working for the service under casual worker contracts told us they understood the reporting structures clearly and described the clinical nurse lead as visible and who provided good support.

Vision and strategy for this this core service

- The service had identified their vision and values, which were set out as four priorities with an aim to provide "the very best of healthcare in northwest England".
- The priorities were set out in a diagram which was on display in the main office area. They included intentions to prioritise service user influence, improve standards of service delivery and performance, strengthen local partnerships and deliver robust quality and governance systems. All staff in the core team understood these priorities and were working towards achieving them.
- There was also a drive from the executive director to increase the activity of the service and 'grow the

business'. The local head of operations spoke daily with the director of operations in Tyneside to monitor and review the activity in the service and discuss any new plans or developments.

Governance, risk management and quality measurement

- The core team which included the five administrative staff, the clinical nurse lead, the service manager and the head of operations attended a daily huddle where they discussed the '3cs' comments and complaints log, local risks, and any other business of the day.
- Items detailed on the 3cs log were transferred over to a risk monitoring sheet if they were not quickly resolved. This was the equivalent of a local risk register and included a description of the risk, impact of the risk, action being taken to mitigate it, and ownership.
- All risks listed on the risk monitoring sheet had the necessary fields completed on the sheet, however once the sheet was full it was filed away so there was no easy way of reviewing risks over the long term.
- There was a corporate risk register but this included only one risk, which was the potential loss of the contract with the host trust last year. This risk was closed in September 2016 after the matter was resolved.
- There was a 'whole system assurance framework' in place which listed four objectives, with risks, controls and assurance level documented. This was overseen by the board.
- Current MSS staff were not involved with the contract negotiations last year. At the time of inspection the head of operations was looking at contingency plans regarding alternative theatre provision in case a similar situation arose again. We saw evidence of this.
- There was a monthly team meeting for the core team, and a joint monthly clinical effectiveness meeting between the service and the host trust where operational matters were discussed. In line with the service level agreement, this was chaired jointly between the directorate manager of medicine and rehabilitation from the hospital, and the head of operations from the service. Issues raised here would either be dealt with through the hospital processes or by MSS, dependent on need. If the head of operations was not able to resolve the matter, it would be escalated to the director of operations in Tyneside.
- The first monthly joint clinical effectiveness meeting took place in February, 2017. We reviewed the minutes, the terms of reference and the standing agenda for this meeting which indicated it will be a useful forum with oversight of matters such as audits, assurance and some elements of clinical governance.
- Senior management team meetings and medical advisory committee (MAC) meetings took place every three months. We saw a selection of minutes from recent team meetings, senior team meetings, operational meetings, MAC meetings and one set of board meeting minutes from 2016.
- The 2017 board meeting had recently taken place and attending the minutes were not yet available. The terms of reference required there to be at least one board meeting annually, with two additional meetings to be convened by the chair and called by the company secretary where there was appropriate business to transact.
- The MAC chair had been in place for two years and there were no plans to rotate this position. We spoke with them and they said the meeting was well attended, which was evidenced in the minutes we reviewed.
- It was evident that individual incidents were discussed at the meetings, even when they had not been formally logged as incidents on the incident reporting system. However, there was not always a clear audit trail of actions following discussion. This meant that there were not always checks and balances in place to prevent the same incidents recurring. When we asked about the outcome of one of these incidents, staff were not entirely sure what it was. The MAC chair thought that he may have missed the next meeting where actions were discussed, however there was no mention of any such discussion in the minutes. Changes have recently been introduced to improve the format of the minutes, and we saw evidence of this.
- We saw the current service level agreement between the service and the host trust, and between the service and other local NHS trusts for ear, nose and throat (ENT) provision, general surgery and diagnostics. All these were up to date.

Public and staff engagement

- The staff we spoke with felt supported by the service. One member of staff had expressed an interest in professional development and this had been formally discussed in their appraisal, and approved by senior managers. The executive director had agreed to fund the relevant training.

- The executive director hosted an annual weekend away for the MSS team which the staff spoke very positively about.
- Staff routinely engaged with patients to gain feedback about the services. This was also done formally through patient feedback surveys. Survey responses showed patients were positive about the care and treatment they received.
- There was no formal public engagement in place, however this was an area the senior team had considered, for example potentially linking in with the NHS patient groups led by the host trust.

Innovation, improvement and sustainability

- The staff felt that that they had good communication in the team and that their daily huddles, mirroring those in clinical areas, were an example of innovative practice. We observed a daily huddle and saw that it was an effective way of ensuring everyone in the core team was up to date with current information about the service.
- The team had made some improvements in their hand and wrist clinics by bringing in a plaster technician from the hospital to support the dressings clinics. This had improved the patient journey as they did not have to be referred elsewhere for another appointment after their follow-up with MSS.
- The management team were also proud of the provision of outpatient clinics within the community, which aligned with the NHS agenda to deliver more healthcare services closer to home rather than in acute hospitals.
- The service was on target to achieve the commissioning for quality and innovations (CQUINs) to develop and implement Local Safety Standards for Invasive Procedures (LocSSIPs) by the end of March 2017.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Take appropriate actions to put in place a registered manager as this is a condition of the provider's registration.

Action the provider SHOULD take to improve

- Take appropriate actions to improve the way incidents are reported and documented so there is a consistent process for managing incidents.
- Take appropriate actions to maintain patients' privacy and dignity in the theatres area.
- Take appropriate actions to maintain up to date and complete staff recruitment records for registrars contracted with the service.
- Take appropriate actions to implement routine infection control audits in the areas they use, at the times they are used.