Castleton Day Unit

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Castleton Day Unit is operated by Day Case UK LLP. Day Case UK LLP is a partnership between Yeovil District Hospital NHS Foundation Trust and Ambulatory Surgery International. Facilities include one operating theatres, a theatre waiting area with eight chairs, a treatment room and a ward area with 27 chairs.

Day Case UK LLP (DCUK) leases facilities, through a local NHS trust, within the community hospital in Sherborne. DCUK shares the Castleton Day Unit with the Ophthalmology outpatient service from the local NHS trust. This is intended to provide local people with comprehensive ophthalmology services.

This was our first inspection of the Castleton Day Unit since it was registered with the Care Quality Commission (CQC) in March 2017. We inspected this service using our comprehensive inspection methodology. Please note that in this report, some dates refer to data provided for February 2017. The service was run by Yeovil District Hospital in that month, and Day Case UK LLP from March 2017. We carried out our inspection on 24 May 2018.

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

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

We rated this service as good overall because:

- Staff received mandatory training and regular updates, including safeguarding training to the appropriate level of their role and responsibilities.
- There was a good safety track record. There had been no never events and no serious incidents during the report time.
- There were systems and processes to ensure the safe use and maintenance of equipment.
- Risk assessments were used to keep patients safe in line with national guidance.
- Staff demonstrated good compliance with the World Health Organisation's (WHO) five steps to safer surgery checklist.
- There were adequate nursing staff levels to safely meet the needs of patients.
- Patient care records were written and managed in a way that protected people from avoidable harm.
- Medicines prescribing and administration were safe and in accordance with local policy.
- Staff were open, transparent and honest about reporting incidents. There were systems to make sure incidents were reported and investigated appropriately.
- Staff had access to policies, standard operating standards and guidelines reflecting evidence based care and treatment, which had been developed in line with national guidance.
- Regular local audits were carried out to monitor performance and to maintain standards.
- Staff monitored patients for signs of pain and ensured additional local anaesthesia was administered if required.
- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- There were processes for obtaining consent.
- We observed caring, respectful and compassionate interactions between staff and patients and their relatives.
- Services were planned and delivered in a way that met the needs of the local population.
- Services were planned, co-ordinated and delivered to consider patients with complex needs to optimise care, treatment and access to services.
- Staff used technology to monitor and thus enhance the delivery of care and treatment.
- The service had policies and processes to appropriately investigate, monitor and evaluate complaints.
- The leadership team of the service had the skills, knowledge and integrity to lead the service.
- There was a culture of openness, candour and honesty amongst staff.

Summary of findings

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

However, we found areas of practice that require improvement:

- Training compliance for dementia awareness, Mental Capacity Act and Deprivation of Liberty Safeguards did not meet local target.
- Processes to meet laser safety did not always meet national guidance.
- The fabric of the building and some equipment was old and described as not always fit for purpose.
- Processes to identify patients' communication needs were limited. This meant the service was not fully compliant with the Accessible Information Standards. These standards became obligatory in 2016 for all NHS care providers.

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

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

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Good

Castleton Day Unit

Services we looked at

Surgery;

Summary of this inspection

Background to Castleton Day Unit

Castleton Day Unit is operated by Day Case UK LLP. The service opened in March 2017. It is situated within a community hospital in the town of Sherborne in Dorset. The service primarily serves the communities of Yeovil, Somerset and Dorset.

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

- Diagnostics and screening procedures.
- Surgical procedures.
- Treatment of disease, disorder and injury.

The service provides ophthalmology, dermatology and minor plastics surgery under local anaesthesia at the Castleton Day Unit.

Our inspection team

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

Information about Castleton Day Unit

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

We carried an announced visit on 24 May 2018.

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

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

Activity (February 2017 to January 2018):

In the reporting period February 2017 to January 2018, there were 1,849-day case episodes of care recorded at the unit. Most of the procedures (97%) were NHS-funded and the remaining 3% were privately funded. The service only treated adults at this location.

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

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

Summary of this inspection

Track record on safety during the period from February 2017 to January 2018:

- No never events.
- No serious incidents.
- 6 clinical incidents (1 low harm, 5 no harm).
- 111 non-clinical incidents.
- No incidences of hospital acquired MRSA
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c-diff)
- No incidences of hospital acquired E-Coli.
- The service had received one complaint since it opened in March 2017.

The service worked closely with the local NHS hospital and another NHS trust from which the facilities were leased. A range of services were provided by service level agreements:

- Medical staff.
- Pharmacy and drugs.
- Pathology.
- Insurance, Clinical Coding, Finance, Clinical Governance, Infection Control, Medical
- Records, Access to Nurse Bank, Risk Management, Human resources and Payroll.
- Marketing and Communications, Non-Clinical Theatre Support, Patient Pathway

Administration and referral to treatment.

- Fire, Health and Safety.
- Housekeeping and domestic services.
- Estates maintenance.
- Medical device management.
- Sterile services.
- Waste management.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Processes to meet laser safety did not always meet national guidance. There had been an external review of laser safety. Actions for improvement were identified in this review to ensure laser safety. Staff had achieved most of the actions identified to ensure laser safety. However, there was one outstanding action, which highlighted significant risk of the laser beam escaping the treatment room due to the fabric of the building.
- The fabric of the building and some equipment was old and described as no longer fit for purpose. This was added to the service's risk register.
- Compliance with hand hygiene did not always meet local targets Compliance with hand hygiene targets was only met in three of the months between March 2017 and December 2017.
- Compliance with mandatory training and regular updates mostly met local targets. Staff received safeguarding training to the appropriate level their roles and responsibilities. However, compliance with dementia awareness, Mental Capacity Act and Deprivation of Liberty Safeguards training was 64% against a local target of 80%.

However, we also found examples of good practice:

- Medicines prescribing and administration were safe and in accordance with local policy.
- There was a good safety track record. There had been no never events and no serious incidents during the report time. There had been no hospital acquired infections since the service opened in March 2017.
- There were systems and processes to ensure the safe use and maintenance of equipment. Staff completed operating theatre checklist and checked emergency equipment. This ensured equipment was working as it should be and emergency equipment was available if it was needed.
- Staff demonstrated good compliance with the World Health Organisation's (WHO) 'five steps to safer surgery' checklist.
- Patient care records were written and managed in a way that protected people from avoidable harm. There were effective processes to ensure safe discharge of patients following day case procedures.

Summary of this inspection

- Staff attended a safety 'huddle' before the morning procedure list started. This provided an opportunity for staff to discuss the day's activity and any issues relating to staffing or equipment concerns.

Are services effective?

Good

We rated effective as good because:

- Staff had access to policies, standard operating standards and guidelines reflecting evidence-based care and treatment, which had been developed in line with national guidance.
- A number of regular local audits were carried out to monitor performance and to maintain standards.
- Staff monitored patients for signs of pain and ensured additional local anaesthesia was administered if required.
- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients. Staff were encouraged to develop their knowledge and skills to improve the quality of care provided. Staff supporting laser treatment sessions were competent to do so.
- There were processes for obtaining consent. There was a policy for consent for examination or treatment, which set out the standards and procedures to ensure health professionals could comply with the guidance.

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

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

Are services caring?

Good

We rated caring as good because:

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

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

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

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

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

Are services well-led?

Good

We rated well-led as good because:

- The leadership team of the service had the skills, knowledge and integrity to lead the service.
- There was a culture of openness, candour and honesty amongst staff. Staff felt valued and empowered to suggest and be involved with service improvement initiatives.
- Staff felt able to raise concerns internally and knew how to do so.
- There were effective governance structures to monitor performance, risks and outcomes to provide safe, good quality care.
- Governance and risk management processes were robust and fit for purpose and demonstrated a positive working relationship between all staff teams and the management team.
- There were systems and arrangements to identify, record and manage risks.
- There were systems and arrangements to identify, record and manage risks. Risks were identified on the risk register with mitigation actions and review dates.
- Information was shared effectively with staff through a variety of ways.
- Information to deliver effective care was readily available.

Summary of this inspection

- There were systems to engage with patients and the public to ensure regular feedback on services.
- There was a clear focus on looking for potential innovative solutions to continue to ensure the delivery of high quality care.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Requires improvement

We rated safe as requires improvement.

Mandatory training

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

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

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

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

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

Safeguarding

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

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

Staff received safeguarding training to the appropriate level relevant to their role and responsibilities. Safeguarding training was delivered during induction and as part of mandatory training provision to meet requirements for regular updates. All staff received level two child protection training and adult safeguarding. Senior nurses received level three adult safeguarding training to ensure they could support junior staff if required. Training records demonstrated staff were up-to-date with their training or were booked onto a training course to ensure timely compliance.

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

Cleanliness, infection control and hygiene

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

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

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

Staff adhered to national guidance for prevention of surgical site infections. Patients received information about showering on the day of surgery before attending the unit. Staff wore appropriate theatre wear and used recommended processes during the procedure to minimise the risk of contamination. For example, we observed staff clean the skin with recommended skin cleansing agents prior to surgery and continued monitoring of patients during the surgical procedure. We observed staff discuss suitable dressings and follow-up arrangements. Staff discussed with patients how to care for the wound including dressing changes, signs, and symptoms of infection, before they were discharged from the service.

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

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

Compliance with hand hygiene did not always meet local targets. The service undertook regular monthly hand hygiene audits. The audit was designed to capture staff compliance with national guidance: five moments for hand hygiene (World Health Organisation (WHO), 2009). The audit looked at overall compliance, compliance by each 'moment' and for different staff groups (medical staff and nurses). The overall compliance with all five moments of

hand hygiene was based on 718 observations between March 2017 and end of December 2017. The result demonstrated between 60% and 98% compliance against a target of 90%.

Staff used personal protective equipment such as gloves and aprons as required and disposed of these safely in bins for clinical waste. Theatre staff wore recommended theatre wear such as hats and masks if they were closely involved with a surgical procedure. Surgeons and scrub nurses completed thorough 'scrub preparation' in accordance with national guidance.

We observed staff clean the operating theatre between each patient procedure. Staff disposed of waste, cleaned equipment and washed the floor. Staff used a diluted chlorine-based solution, which was made up daily. The chlorine-based tablets were stored next to the sink in the dirty utility room alongside formaldehyde solution. Both solutions can cause irritation by accidental exposure or spillage and should not be stored in an accessible place. We discussed this with managers at the time of our inspection. Following the inspection, we received a Control of Substances Hazardous to Health (COSHH) review/risk assessment in response to the concerns we raised. The review contained an assurance that the service met their guidelines. We also looked at national guidance and asked our policy advisory team and concluded that risks were well managed at this location.

The operating theatre and the ward areas were visibly clean. Equipment was visibly clean and we saw green 'I am clean' labels placed on trolleys and equipment that had been cleaned and were ready for use. The service used disposable curtains to provide privacy for patients getting ready for surgery. These curtains were dated and changed every four months or sooner if required. Furniture and fittings were easy to clean, disinfect and maintain. Staff reported a good standard of cleanliness and when speaking to patients everyone commented on the high standard of cleanliness in the unit.

There was a dedicated team of cleaners from an NHS trust, who ensured the areas were cleaned regularly. There were cleaning checklists to ensure the ward and theatre departments were cleaned regularly. Cleaning audits demonstrated 100% compliance, meaning that all areas including difficult to reach places, were clean when they were audited.

Environment and equipment

The design of the Castleton Day Unit had challenges regarding keeping people safe. Day Case UK LLP had made the premises as safe, effective and efficient as possible within the constraints of environment The Castleton Day Unit was on one level with a slope down to theatres and had signs and used wheelchairs to ensure patient safety when moving to theatre. However, the environment could lead to difficulties due to the patient group using the service, which included patients with mobility issues. The environment of the operating theatre was entered as a risk onto the service's risk register. Concerns included the age of the building/fabric of the building and of the equipment such as the operating light, which was described as no longer fit for purpose.

A comprehensive action plan for ophthalmology was used to review procedures to ensure patients had safe care while in the unit. The ability to see more patients was affected by the environment but staff said the safety of the patients within the service was considered before further development.

Processes to meet laser safety did not always meet national guidance. There was a guidance document referred to as Local Rules containing information about safety standards at the unit specifically that should be met each time laser treatment was administered. This included restricting access to the operating theatre during treatment to avoid accidental exposure. The service used clear signs on doors when administering laser treatment, and locked the door from the inside during. Other safety practices include covering all blank surfaces to avoid reflection of the laser beam and the use of personal protective equipment for staff. The service had had an external review of the Local Rules in February 2018. The service met most of the criteria to provide safe laser treatment. The review report included an action plan of eight actions required to achieve full compliance for the safe administration of laser treatment in ophthalmology. Of these actions, seven had been completed at the time of our inspection. There was one action, which highlighted the significant risk of the laser beam escaping from the room via gaps between double doors, ventilation flaps and around the blind covering the window. The report also highlighted it was not known if the blinds were of adequate quality to prevent penetration of the laser beam. This risk had been highlighted to the

facilities and estate manager and the risk manager on 6 March 2018. The service was still awaiting a reply from the NHS trust landlords on 31 May 2018. This risk had not been entered onto the service's risk register.

It is a legal requirement of the Medicines & Healthcare Products Regulatory Agency (MHRA) that there is an appointed Laser Protection Advisor (LPA). The services of the LPA were provided by a NHS trust in the Midlands. The MHRA also recommended the appointment of a Laser Protection Supervisor (LPS). There were two senior nurses trained as laser protection supervisors. We reviewed their certificates, which confirmed attendance of a 'laser safety core of knowledge' course in November 2016.

There were clean and dirty utility rooms to ensure equipment and waste were separated from clean and sterile equipment. It was not a purpose-built unit but the area had been re-purposed and as such was not required to fully comply with the Department of Health: Health Building Note 10-02 (2007). The building was old with stairs and many corridors, which meant it could be difficult to find the way around.

There were scrub and gowning rooms for surgeons and scrub nurses for preparation to undertake sterile procedures. These were large enough for two people to scrub at the same time using recommended sinks and hands-free operated taps. There was a preparation room for each theatre, where staff could prepare the sterile equipment used during the operation. This ensured staff could prepare equipment safely without accidental contamination of sterile equipment laid up on trolleys.

Fire safety was managed effectively. Fire exit routes were clearly marked and free of permanent obstacles, although some portable equipment was stored in corridors. Fire extinguishers and fire blankets were in date of their annual checks. There was regular fire alarm testing. Staff told us there had been a recent fire drill/scenario training March 2018) to rehearse safe evacuation of patients in the event of a fire.

The unit had adequate security systems to protect patients and staff. This included CCTV and key pad access to locked areas. There were keypads on doors to clinical areas such as clean and dirty utility areas, to ensure only authorised staff had access. Staff said they felt safe in their working environment.

There were systems to ensure the safe use and maintenance of equipment. Staff checked emergency and surgical equipment daily. We checked the resuscitation trolley and found randomly chosen consumables and medicines to be stored in unbroken packaging and within their expiry date. The was a box containing emergency medicines marked with an expiry date (30 September 2018). This was tamper evident and staff recorded the number of the tag to ensure unauthorised access was recognised. Checklists confirmed that the resuscitation trolley was checked every day the unit was open in the period we reviewed (between 21 January and 24 May 2018).

There was a separate tamper evident anaesthetic box which included additional equipment in case general anaesthesia was required. Records we reviewed demonstrated the box was checked every month (from January 2018 to May 2018) in line with policy. However, staff did not document the tag number so processes to ensure medicines were not tampered with were not entirely secure. We brought this to the attention of the sister on duty at the time of our inspection.

We saw a range of equipment was readily available and staff said they had access to the equipment they needed for the care and treatment of patients. Specialised equipment was ordered in advance in line with the standard operating protocol. Disposal equipment was delivered daily from the local NHS hospital.

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

Equipment was maintained and serviced regularly. We reviewed a random sample of equipment in the ward area and in the operating theatre. We checked three randomly chosen pieces of equipment and found they were all within their annual service date. Device servicing and maintenance was carried out by the local NHS hospital as part of a service level agreement. Senior leaders were informed by email if there were issues about equipment.

The service kept an asset register, which was managed by the local NHS hospital as part of a service level agreement. This showed details of the device and service completion date and regularity. An equipment replacement

programme had been adapted from and with the permission of the local NHS hospital. We saw details of the equipment replacement budget and capital budget summary.

There were daily theatre safety checklists for staff to complete. Nursing staff were required to carry out theatre cleaning and checklists at the beginning of the day and at the end of the day. Checks included daily checks and cleaning of the operating theatre and ensuring equipment was plugged in for charging overnight. In addition, they were weekly and monthly check reminders for staff, which also provided an audit trail of checks carried out. Records we looked at demonstrated relevant checks had been completed on the days the operating theatre was in use (during March, April and May 2018).

Regular stock takes were completed and included checking of expiry dates and ensuring appropriate stock rotation. We checked random consumables and found these were stored in unbroken packaging and within their expiry date.

Assessing and responding to patient risk

Risk assessments were used to keep patients safe and were in line with national guidance. Staff completed patient risk assessments when admitting adult patients for day surgery or endoscopy procedures. Information was gathered from and about the patient to ensure, all risks were assessed and managed. Patients attending for day surgery procedures had attended a pre-operative assessment in an outpatient clinic prior to their day surgery. There was a day case surgery selection criteria checklist designed to ensure patients were suitable for day surgery. The criteria included an assessment to ensure patients were medically suitable, had somebody to look after them and that the proposed surgical procedure was suitable for day case surgery. At this location, staff carried out surgical procedures under local anaesthesia only.

There was clear guidance for staff to follow regarding patient groups who were exempt from a venous thromboembolism (VTE) risk assessment. There were no procedures carried out under general anaesthesia at the location so VTE risk assessments did not apply to patients treated at the Castleton Day Unit.

Staff monitored patients undergoing surgical procedures. A member of the clinical team observed patients undergoing surgical procedures under local anaesthesia. They observed patients for signs of discomfort and pain such as grimacing and frequently asked patients how they were feeling. This helped to reassure the patient, and the general conversation helped to distract the patient during the procedure.

Staff were aware of policies, procedures and pathways used to respond to deteriorating patients. There was monitoring and emergency equipment available in the event of a clinical emergency. Staff dialled 999 if patients required transfer to the emergency department. However, staff told us the emergency ambulance service considered patients to be in a safe place so transfers could be delayed. The service had raised this as a concern with the local NHS ambulance service.

Staff demonstrated good compliance with the World Health Organisation's (WHO) 'five steps to safer surgery' checklist. This is an initiative designed to strengthen the commitment of staff to address safety issues within operating theatres. Staff understood the WHO checklist and its importance and the practice was embedded into daily routines. The WHO checklist included assurance of positive patient identification and surgical site marking. The service audited WHO compliance by auditing patient records and undertake observations of staff completing the checklist. Audit results demonstrated improved compliance from 91% to 100% compliance between March 2017 and January 2018 in the day surgery theatre against a target of 100%. The audit also assessed how well staff completed and used the form. In the same period, the incomplete fields ranged from 30% incomplete in February 2017 to a much-improved result of 3% in December 2017.

We observed good practice when staff completed the sign in and sign out stages of the WHO checklist. Staff were attentive and clear when checks were made. For example, when checking the number of instruments and swabs used during a minor operation. Two members of the clinical team counted out loud together to ensure all surgical instruments and swabs were accounted for. This was compared with a running total added to a whiteboard in the operating theatre and was accurate.

Nursing and support staffing

There were adequate nursing staff levels to safely meet the needs of patients. Staff were employed to work across both Day Case UK LLP's locations. The service used the Association of Perioperative Practice (AfPP) guidance to determine safe and effective staffing levels. Staffing for

patients in the perioperative setting guidance was considered and used to ensure safe staffing across all ward, theatre and recovery areas. This guidance supported the review of staffing for both local and general anaesthesia sessions in theatre and safe recovery and day ward staffing. At the time of the inspection, staffing levels were appropriate in the ward, day surgery theatres and the endoscopy suite. There were 20.4 whole time equivalent (WTE) registered nurses across the whole unit with 9.9 WTE for operating department practitioners (ODPs) and healthcare assistants (HCAs). At the time of our inspection, there were four WTE registered nurse vacancies.

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

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

Medical staffing

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

Records

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

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

Staff used evidence-based care pathways during a day case surgery procedure. Pathways included pre-operative assessment, pre-operative checklist, and standard care procedures during the operation such as the 'five steps to safer surgery' and observations. Following the procedure, staff followed the care pathway to document care provided during recovery, and discharge arrangements for patients.

Staff gave patients a copy of their discharge/procedure summary so patients could share important information if further medical care was required. Staff ensured a copy of the discharge summary was sent to patients' GPs. The service had plans to audit this to ensure all discharge summaries were sent to GPs within 24 hours of patient discharge.

There was a records management policy which outlined the procedures for the creation, management, filing, storage, retrieval and destruction of health records. Medical notes were stored securely in cupboards to ensure confidentiality. Patient records demonstrated a multidisciplinary collaborative approach to patient care and were well maintained. Records were transported to the unit in secure plastic boxes with security ties and stored in a locked cupboard every morning and returned to the local NHS hospital at the end of each day.

We reviewed four sets of notes. All records were complete, accurate, legible and up-to-date. All clinical staff completed informative evaluation notes and reflected the needs of patients. We checked a range of information including pre-assessment, consent, patient pathway, observations, pain management, allergies, WHO checklist for safer surgery, discharge checklist and summary. Information was clear and concise and care plans were up-to-date.

Medicines

Medicines were administered, stored and managed in a way that kept people safe from avoidable harm. Staff had access to the unit's medicines management policy, which

was adapted from and with the permission of the local NHS trust's policy. This defined procedures to be followed for the management of medicines and included prescribing, ordering, storage, administration, recording and disposal of medicines. Staff were knowledgeable about the policy and told us how medicines were ordered, recorded and stored. We checked ten medicines across theatres, recovery and the endoscopy rooms. These were within their expiry date, and stored safely in locked cupboards. We checked a random sample of medicines in the operating theatre and in the ward area and found the medicines we checked were within their expiry date, and stored safely in locked cupboards.

We looked at the medicines storage audits, storage security, medicines records, and supply and waste-disposal processes. Medicines, including those requiring refrigeration, were stored safely and kept within the recommended temperature range. During our inspection, we found all medicines stored securely, and were only accessible to authorised staff. All drug cupboards were locked and the stocks well organised. Fridge temperatures were monitored remotely by an external company. If fridge temperatures were observed to be higher than recommend, the external company informed staff by email and contacted engineers to attend if required. We looked at data showing the minimum, average and maximum temperatures of four fridges. Data confirmed temperatures were monitored every day in the period we checked (between 1 March 2018 and 31 May 2018). However, one of the fridges displayed abnormal high temperatures on 42 days between 19 April and 31 May 2018. We asked for further information about this and we were told that all medicines had been removed from this fridge and the fridge was no longer in use.

By agreement, the service used the pharmacy services at a local NHS trust. The pharmacy was open on Monday to Friday from 9am to 5:30pm, and on Saturday from 9am to 4pm. Medicines management was linked with the pharmacy service. Medicines were ordered every Tuesday and stock was checked monthly. Any out of date medicines were discarded safely. Those expiring at end of that month were highlighted and at the front of the cupboard for next use.

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

During the period from November 2017 to March 2018, there were four medicines' incidents reported. Records showed the immediate action taken, a review of possible underlying causes and actions taken to minimise the risk of a reoccurrence. Three of the incidents were related to pharmacy supply issues. The other related to the wrong medicine having been administered.

Incidents

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

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

The service reported six clinical incidents between February 2017 and end of January 2018. Of these incidents, one was categorised as low harm and five were categorised as no harm. There were 111 non-clinical incidents. These non-clinical incidents are all those which do not involve patient care, such as equipment failures.

Staff were aware of their responsibilities to raise concerns and understood the process of how to report incidents. The service used an electronic incident reporting system. All

staff received training on incident reporting and were encouraged to report incidents as they occurred. Staff said they would have no hesitation in reporting incidents, and were clear about how they would report them.

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

Learning from incidents were shared with staff to improve the services delivered. Staff provided an example of how learning or changes had been made following an error in the recording of administration of eye drops. As a result, the eye drop prescription chart was reviewed with pharmacy, managers and the ward. Changes were made to the way the eye drops prior to intra-ocular surgery was recorded. This was to ensure appropriate drugs were administered in relation to dilation or constriction of the eye. The chart was amended to clearly show which drugs should be used and the frequency.

We reviewed an investigation into one of the reported incidents. Learning or actions were identified to reduce the likelihood of the incident occurring again. Staff demonstrated an understanding of duty of candour responsibilities. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Emergency awareness and training

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

The NHS trust who managed the premises carried out monthly generator tests to ensure ongoing power supply in the event of an electrical supply fault. Staff were aware of when these happened and had a list of all the dates when the generator would be tested

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

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

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

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

were some SOPs that had gone past their review date. For example, the SOP for 'local guidance for topical ointment' should have been reviewed in October 2014. Leaders told us they continued to work on the development of SOPs and policies specific to the Day Case UK service.

Staff linked with clinical specialities within in the local NHS hospital, which allowed sharing of the most up to date information and processes. The registered manager was copied into all governance oversight about care concerns and equipment updates and received national alerts regarding equipment from the Medicines and Healthcare Products Regulatory Agency (MHRA).

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

Nutrition and hydration

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

Pain relief

Staff monitored patients throughout procedures. If patients were in discomfort this was highlighted to the surgeon so additional local anaesthetic medicines could be administered if required.

Staff provided information about pain management to patients before they were discharged from hospital.

Patient outcomes

The service had limited participation in national patient outcome audits through their close working relationship with the local NHS trust. However, data was not available to enable comparisons with other providers which meant the service was unable to benchmark their performance against other and similar services.

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

Competent staff

Staff mostly had the skills, knowledge and experience to deliver effective care and treatment to patients although staff did not receive specific training in how to support patients living with dementia. Local induction packages for staff supported the ethos of effective care through bespoke training to ensure the skills required were assessed and taught. There was an induction programme for new starters, current staff changing job /work area and bank/ agency staff new to the area. This included an introduction to the team and orientation to the department, resuscitation procedures and fire safety procedures and assembly points.

Staff were encouraged to develop their knowledge and skills to improve the quality of care provided. There was a comprehensive competence framework designed to ensure staff received required training and were competent to carry out their job. Staff received specialty specific training and updates to ensure the most recent information was shared. Updates, learning and staff development was confirmed through appraisals. Staff said they were encouraged to be responsible for their own competency. Data confirmed all staff had received their appraisal within the last 12 months at the time of our inspection.

Some staff attended external groups where information was shared. For example, some staff attended southwest meetings in ophthalmology. Some staff had also attended national or regional conferences to stay abreast of current thinking in day case services.

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

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

Staff were encouraged and supported to undertake further post registration courses to enhance their knowledge and skills. For example, ten registered nurses held a mentorship course allowing them to mentor student nurses on placement. Staff supporting laser treatment sessions were competent to do so. Two nurses were appointed as laser

protection supervisors in line with national guidance. There were four nurses who had attended and completed additional laser training. Staff had attended a scenario-based training day in ophthalmology. This has helped to highlight clinical and operational issues.

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

Multidisciplinary working

We saw evidence that staff worked professionally and cooperatively across different disciplines. This was to ensure care was coordinated to meet the needs of patients. We observed good multidisciplinary team working across the unit. Staff reported good multidisciplinary team working with liaison to discuss patients' care and treatment.

Information was shared with GPs on discharge from the service. Nurses completed the discharge summary and a final assessment summary was completed on the electronic record system. A discharge letter was then created and given to the patient. Written instruction was provided for patients and their carers for post procedure care.

Seven-day services

Additional ophthalmology operating lists were scheduled on Saturdays to reduce waiting lists. The service had successfully trialled a 'one stop cataract' list on one 'Super Saturday'. The service had identified 17 patients who might benefit from a consultation with the consultant, pre-assessment and the cataract operation in one day. Of the 17 patients, 16 patients received their cataract operation on the same day. Staff were engaged with the final review of the business model for continuing this service which was to be presented to the board. In the meantime, the bookings team kept some slots on the Saturday afternoon list free to be used for optional 'one-stop' patients, if it was safe to proceed with surgery on the day.

Health promotion

We observed staff provide information about sun protection for patients attending for removal of skin lesions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

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

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

There was access to a Deprivation of Liberty Safeguards (DoLS) authorisation policy, which aimed to set out the

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

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

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

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

Staff showed an encouraging, sensitive and supportive attitude to patients and their relatives. Throughout our inspection, we saw patients being treated with compassion, dignity and respect. Care from the nursing, medical staff and support staff was delivered with kindness and patience.

We observed all staff taking time to talk to patients in a manner that suited their needs. They involved and encouraged patients to be involved in their own care. Staff were open, friendly and approachable for patients, but always remained professional. We observed excellent interactions between staff and patients. The staff were skilled in talking to and caring for patients.

Patients and their relatives we met spoke highly of the service they received. All the feedback we received was positive about the care they received. The comments we received included, "the staff have been fantastic", and another said, "I've been treated with dignity and respect and felt listened to. I can't thank everyone enough."

We observed good attention from all staff to patients' privacy and dignity. Doors were closed in private rooms when necessary. Voices were lowered to avoid confidential or private information being overheard.

Comment cards were displayed on noticeboards in the staff room. Comments from patients were mostly positive and included examples such as, "Looked after perfectly" and "Clear explanation and informative staff (particularly surgeon)."

The service used the NHS Friends and Family Test to find out if patients would recommend their services to friends and family if they needed similar treatment or care. During the period from August 2017 to January 2018, the response rates (the number of patients who completed the questionnaire) ranged from between 8% and 49%. There were positive results with data from this period showing between 93% and 100% of patients would be either likely or extremely likely to recommend the service to friends and family if they needed similar treatment or care.

We sought the views of patients before and during the inspection by leaving comment cards and boxes to leave feedback. We received six completed feedback cards containing the views of patients about the care they had received. Feedback responses were positive with comments such as, "the treatment and care I have received has been exemplary and cannot be criticised"," I cannot fault the service", "staff are always very caring and professional". However, concerns about long waiting times and lack of parking were also mentioned.

Understanding and involvement of patients and those close to them

Patients were involved in every stage of their care and treatment. Patients said all procedures had been explained, they felt included in the treatment plan, and were well informed. This included the consultant explaining the surgery events in detail and nurses talking patients through information leaflets. Staff recognised and supported patient anxieties.

Emotional support

Good

Surgery

We observed staff explaining things to patients in a way they could understand. For example, time was allowed for the patient to ask whatever questions they wanted to. One patient commented they had been "updated on everything in a language I understand. The surgeon explained everything to me."

Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. They were knowledgeable about the framework to support communication with patients who were non-English speakers, or for whom English was a second language. Support was also available for patients with hearing or visual impairment, or who had learning disabilities.

Are surgery services responsive?

Good

We rated responsive as good.

Service delivery to meet the needs of local people

Services were planned and delivered in a way that met the needs of the local population. The service worked with the local NHS hospital and other stakeholders including GPs, to meet the needs of the local population. Services were provided Monday to Friday from 8am to 6pm. There were additional Saturday lists for ophthalmology procedures. Patients were booked onto sessions through the local NHS hospital contract ophthalmology bookings arranged directly with the day surgery service.

The service provided day case surgery services under contract with the local NHS trust. Patients were assessed through the NHS trust's pre-assessment processes to ensure they were suitable for day case surgery. Further discussion was undertaken with clinical staff through emails to key staff and weekly scheduling meetings. This was to ensure the scheduling met the needs of the population to meet expected waiting times for patients from referral to treatment.

There was a waiting area, which was shared with an outpatients department. There was a theatre waiting area with eight chairs, one treatment room and one operating theatre. There was a kitchen area for staff to prepare refreshments for patients following surgery.

There was limited parking at the site. Patients and their relatives found it difficult to find a space in the car park. Others had decided to take a taxi as they had been forewarned by relatives about the difficulties.

Meeting people's individual needs

Services were planned, co-ordinated and delivered to consider patients with complex needs to optimise care, treatment and access to services. Specific patient needs were highlighted through scheduling or from specialist teams and were acted upon to provide the patient with the most supportive, caring service possible. There were codes on the electronic systems to alert staff to specific physical or psychological support required.

Reception staff greeted patients and booked them onto the electronic record system. Patients were directed to the adjoining waiting area until they were called through by the nurse. There were a consulting rooms where nurses took patients to complete paperwork required for their procedure and to meet the surgeon. Following their procedure, staff escorted patients to the ward area for recovery before discharge.

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

There was a dementia strategy with a plan for the local NHS trust and subsidiary organisations, to deliver high quality person-centred care for people living with dementia and their carer's. The strategy included key objectives for staff training, care delivery, carers support programme and partnership working. The strategy was not specific to Day Case UK. Staff had not received dementia awareness training and updates as part of their mandatory training. However, staff told us they had received an update on a

clinical governance day, which they had found useful. Following the inspection, we were informed action had been taken to add dementia training to mandatory training requirements.

Portable hearing loops and mobility equipment were available across both sites to support those patients who required mobility support such as wheelchairs and hoists to assist them to their surgery with privacy and dignity. This requirement would normally be known in advance through booking teams and scheduling. Codes were used on theatre lists to protect patient dignity and privacy of information.

There was a standing operating procedure (SOP) providing guidance on chaperone services available to both staff and patients. The SOP provided advice on the use of chaperones to safeguard patients and staff.

Information and post discharge support was provided with procedure-specific leaflets. These included advice following cataract surgery with contact telephone numbers if patients had any concerns. Other leaflets provided information about care of the stitched wound, split skin graft after care, and a post cataract surgery eye drops chart timetable.

Access and flow

Patients were given appointments but could change these if they were not able to attend. Services were provided Monday to Friday from 8am to 6pm with additional Saturday lists when required to reduce waiting lists. If patients required further follow-up appointments, staff ensured these were made before the patients were discharged.

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

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

Referrals to treatment patient waiting times were within the remit of the local NHS hospital. Day Case UK LLP (DCUK) supplied a service to meet the needs of the organisation through the agreed contract. General managers within the local NHS hospital held responsibility for the referral to treatment (RTT) requirements. They worked closely with the DCUK registered manager and the DCUK lead team to achieve their needs. There was a weekly scheduling meeting to review the previous week's performance, forward view of lists, waiting list management, capacity and weekly room schedule. Patients were booked onto sessions through the NHS local hospital contract for all specialities apart from ophthalmology, which was led by the Day Case UK LLP. The weekly scheduling meetings provided an opportunity for feedback between the local NHS hospital and DCUK about previous sessions and how to improve booking and patient pathways.

Monthly quality reports showed the number of cancellations by the service. There were 29 cancelled procedures between August 2017 and January 2018. This was an average of five procedures per month, which was below the maximum target of no more than 20 cancellations per month.

The service had good utilisation rates in the operating theatre. Data demonstrated the average use of operating theatre time was 98% between February 2017 and end of January 2018. Utilisation and productivity was reviewed monthly and discussed at the board meeting.

Patients' appointment times were batched so that all patients arrived at the same time for the morning and afternoon procedure lists. This was because the surgeon saw patients prior to starting the operating theatre list to obtain consent. Staff kept patients updated on waiting times and there were posters in the waiting areas providing information about the appointment time/schedule. However, some patients felt there was "too much waiting."

Good

Surgery

The service had acted to reduce incidents relating to ophthalmology appointments. There had been a number of incidents reported related to booking of ophthalmology appointments. When these were investigated, managers found the workload for staff involved was not realistic and an additional member of staff had been appointed to support booking processes.

All staff attended a 'huddle' before the morning procedure list started. This provided an opportunity for staff to discuss the day's activity and any issues relating to staffing or equipment concerns.

Learning from complaints and concerns

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

Leaflets and posters were available around the unit informing patients about how to make a complaint or raise a concern. Patients we spoke with were aware of how to raise a concern or make a formal complaint. However, none of the patients we spoke with during the inspection had any complaints about the service. Comments we heard were very positive. There had been no complaints during the period from February 2017 to January 2018.

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

The individuals responsible for overseeing the management of complaints were the registered manager and the theatre lead. Complaints and concerns reported to the local NHS hospital's patient advice and liaison service (PALS) team were logged electronically on a shared system and investigated by the responsible individual. These were subsequently reported through the respective governance committees.

Learning from complaints was shared with staff through the daily huddles, nurse leads meetings and through the quality and board meetings as required. Learning from concerns and complaints were also included in hospital wide forums to ensure pathway improvements were shared and embedded.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership

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

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

The service worked closely with the local NHS trust. The senior leadership teams interacted daily. This was to ensure any changes to scheduling were made or urgent and emergency procedures could be treated. The registered manager had a dual role as they also held a senior leadership position within the local NHS trust.

Although the dual role was demanding, the registered manager felt it was an advantage to ensure a close working relationship and this ensuring a safe and efficient environment to meet the needs of patients.

Vision and strategy

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

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

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

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

Culture

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

Staff felt empowered to suggest and be involved with service improvement initiatives. Staff stated the processes were less cumbersome than working within the NHS although still subjected to the highest scrutiny to ensure new models were evidence based and safe for patients. Frontline staff and senior managers were passionate about providing a high-quality service for patients with a continual drive to improve the delivery of care.

All staff we met said they felt valued and part of the team. Staff feedback was collected and shared in daily huddles to improve the service. Staff had taken part in a staff survey and the results from this was still being collated. We saw monthly staff newsletters which included details of new starters, training, recruitment, procedural updates, departmental news, social events and recognition of continued hard work by the teams. This was emailed to staff and hard copies were available on the unit.

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

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

Good

Surgery

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

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

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

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

Governance

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

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

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

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

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

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

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

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

Managing risks, issues and performance

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

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

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

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

Managing information

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

Good

Surgery

Information to deliver effective care was readily available. There was a range of documentation templates such as care pathway and these was easily accessible. An 'important documents' folder was kept in the staff rest room to be read and initialled by all staff. Documents included changes, for example, to data protection, duty of candour, admission criteria, sepsis screening, and safeguarding adults and children.

The service had direct access to electronic information held by community services, including GPs. This meant hospital staff could access up-to-date information about patients, for example, details of any prescribed medicines.

There were three IT systems used, which did not interface and some staff were frustrated about the repetitive nature of data entry. Although repetitive, staff and managers were confident that data was entered in a timely way and accurately.

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

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

Engagement

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

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

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

Learning, continuous improvement and innovation

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

There was a comprehensive action plan developed following a review of the DCUK Ophthalmology service. This involved all staff working across the ward and theatre areas. Training, equipment, patient pathways, and booking times had all been reviewed, and continued to be following patient and staff feedback. The action plan involved clinicians, DCUK, and staff from the local NHs hospital working together to ensure a safe and effective patient experience in the unit. Theatre processes and equipment had been reviewed to support safe, quality care.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the environment meets the standards to deliver safe laser surgery procedures.

Action the provider SHOULD take to improve

- Carry out a risk assessment of the fabric of the building and the ageing equipment to ensure these are fit for purpose.
- Improve compliance with the five moments of hand hygiene.
- Improve training compliance with dementia training, Mental Capacity Act and Deprivation of Liberty Safeguards to meet local targets.
- Enhance participation in national audits to enable benchmarking of practice.
- Review processes for the recording of additional contemporaneous documentation about decision making records in accordance with national guidance.
- Review processes to flag up patients' communication needs to achieve full compliance with the Accessible Information Standards.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The environment to deliver laser procedures did not provide adequate safety. There was a significant risk of the laser beam escaping the treatment room due to the fabric of the building.