Cobham Day Surgery

Quality Report

Cobham Cottage Hospital
168 Portsmouth Road
Cobham
KT11 1HS
Tel:01932 588400
Website:www.epsomedical.co.uk

Date of inspection visit: 13 and 14 September 2016
Date of publication: 09/12/2016

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?	Requires improvement

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

We carried out a comprehensive inspection of Cobham Day Surgery on the 13 and 14 September 2016 as part of our national programme to inspect and rate all independent hospitals. We inspected the core services of surgery and outpatients and diagnostic imaging as these incorporated the activity undertaken by the provider, Epsomedical Limited, at this location.

We rated the core service surgery as requiring improvement and outpatients and diagnostic services as good, with the hospital overall rated as good. Our concerns were that aspects of medicines management were not robust in surgery, some equipment was not consistently checked to ensure its safety and processes to ensure fit and proper persons were employed at board level did not meet the relevant regulations. Although some elements of the service required improvement, the overall standard of service provided outweighed those concerns. We have deviated from our usual aggregation of key question ratings to rate this service in a way that properly reflects our findings and avoids unfairness.

Are services safe at this unit?

We found improvements were required to minimise risks and promote safety as the management of medicines and equipment was not always robust.

However, we also found there were systems to report and investigate safety incidents and to learn from these. Risks to patients were understood and actions taken to mitigate them. The unit employed sufficient numbers of staff with the necessary skill, qualifications and experience to meet patients' needs.

Are services effective at this unit?

Care was planned and delivered in accordance with current guidance, best practice and legislation. There was a programme of audit to ensure good practice was maintained and patients experienced good outcomes. Patients' pain was well controlled.

Are services caring at this hospital?

Patients were treated with kindness and respect. Patients gave positive feedback and said they were treated with compassion and dignity.

Are services responsive at this hospital?

Services were planned to meet the needs of patients and give them a choice as to where they received their care and treatment. Patients referred to the unit were consistently seen and treated promptly within nationally set timescales. There were arrangements to ensure that the individual needs of patients were assessed and met. Complaints were appropriately investigated in a timely way**.**

Are services responsive at this hospital?

There were insufficient processes to ensure board members fulfilled the "fit and proper person" requirements. However, leaders were visible and were valued by staff and there was a clear vision of what the service aimed to achieve currently and in the future. Information technology was used innovatively to improve the efficient running of the service.

Our key findings were as follows:

- There were adequate systems to keep people safe and to learn from critical incidents.
- The hospital environment was visibly clean and well maintained and there were measures to prevent the spread of infection.

Summary of findings

- There were adequate numbers of suitably qualified, skilled and experienced staff (including doctors and nurses) to meet patients' needs and there were arrangements to ensure staff had the competency to do their jobs.
- There were arrangements to ensure that patients had access to suitable refreshments, including drinks, and were not starved pre-operatively longer than was necessary.
- Care was delivered in line with national guidance and the outcomes for patients were good when benchmarked.
- Arrangements for obtaining consent ensured legal requirements and national guidance were met, including where patients lacked capacity to make their own decisions.
- Patients could access care in a timely way without undue delay.
- The privacy and dignity of patients was upheld.
- The hospital management team were visible and were supported by the staff and there was appropriate management of quality and governance.

We noted the following examples of outstanding practice:

- The provider had direct access to electronic information held by community services, including GPs. This meant that unit staff could access up-to-date information about patients.
- Epsomedical Limited had invested in bespoke, integrated IT systems to ensure efficient management of staff, finances, other resources, clinical activity and governance.
- Specific procedures were separated by gender, with females undergoing the procedure on one day and males another day to ensure compliance with the Department of Health's same-sex accommodation guidance.

There were also areas of where the provider needs to make improvements.

Importantly, the provider must:

- Introduce systems to ensure the checking and availability of anaesthetic equipment.
- Introduce a robust system for the reconciliation, storage and monitoring of medicines.
- Introduce processes to ensure compliance with the 'fit and proper person' requirement.

In addition the provider should:

- Consider how to raise awareness of the complaints procedure for both staff and patients
- Review processes on assessing pain to ensure they meet best practice
- Take action to be assured all cleaning schedules are implemented and monitored.
- Improve awareness of the 'duty of candour' obligation amongst the management team.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Requires improvement** 	• Systems to store, monitor and ensure the availability of medicines were not robust. • Equipment was not consistently checked or maintained to ensure it was ready for use and some items of emergency equipment were not readily available. • There were insufficient processes to ensure that board members fulfilled the “fit and proper person” requirements and there was limited understanding by some senior leaders of the duty of candor regulations. • There was some limited awareness of complaints procedures for both staff and patients. • However, we also found staff understood and fulfilled their responsibilities to raise concerns and report incidents and these were appropriately investigated and learning shared. There were effective systems to assess and respond to patient risks and infection prevention and control practices were in line with national guidelines. • There were sufficient numbers of staff with the necessary skill, qualifications and experience to meet patients’ needs. • Care was planned in accordance with current evidence-based guidance, standards, best practice and legislation. The unit monitored this to ensure consistency of practice and patients experienced good outcomes. • Patients were treated with kindness and courtesy and their privacy and dignity promoted. There were arrangements to respond to individual needs. • Leaders were visible and were valued by staff. There was a clear vision which was shared through the service. There was innovative use of new technology to run the service.

Summary of findings

Outpatients and diagnostic imaging

Good

- The unit had systems and processes in place to keep patients free from harm. Staff were aware of how to report incidents which were then investigated, infection prevention and control practice met national guidelines and the management of medicines was appropriate.
- Care was delivered in line with national guidance and the unit had a comprehensive audit programme in place to monitor services and identify areas for improvement.
- There were sufficient numbers of appropriately trained and competent staff to provide their services.
- Patients were treated in a kind, caring and considerate manner and staff respected their privacy and dignity.
- Appointments could be accessed in a timely manner at a variety of times throughout the day; waiting times met national targets
- Managers were visible, approachable and effective. There were robust systems and processes in place in relation to governance and quality assurance.

Summary of findings

Contents

Good

Cobham Day Surgery

Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Cobham Day Surgery

Cobham Day Surgery is operated by Epsomedical Limited. It is a private day surgery and outpatient unit in Cobham, Surrey, although 99% of the work undertaken is on behalf of the NHS. The unit primarily serves the communities of Cobham and Epsom but it also accepts patient referrals from outside this area. The service opened in 2005 when Epsomedical Limited was invited by the NHS to set up an additional day surgery unit.

The service is provided to adults over 18 years since May 2016 when Epsomedical Limited no longer accepted referrals for under 18's following review of the service provided and after consultation with the local Clinical Commissioning Group.

The hospital has had a registered manager in post since September 2013, and has a designated Controlled Dugs Accountable Officer who was the medical director. The unit has been registered for the following regulated activities since January 2011:

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

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. Prior to this inspection, we had not inspected and rated this service using our new methodology. We last inspected the service in July 2013 and we did not identify any problems at this time.

Our inspection team

The team that inspected the service was led by Shaun Marten, CQC inspection manager. The team comprised two CQC inspectors, and three specialist advisors with expertise in surgery, surgical nursing and radiography. The inspection team was overseen by Alan Thorne, Head of Hospital Inspection.

Why we carried out this inspection

We carried out a comprehensive inspection of Cobham Day Surgery on the 13 and 14 September 2016 as part of our national programme to inspect and rate all independent hospitals.

How we carried out this inspection

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We requested information from the local clinical commissioning group. We placed comment boxes at the hospital prior to our inspection which enabled patients to provide us with their views. We received 45 comments.

We carried out an announced inspection on the 13 and 14 September.

We held a focus group where staff could talk to inspectors and share their experiences of working at the unit. We interviewed the management team and chair of the

Summary of this inspection

Medical Advisory Committee. We spoke with a wide range of staff including nurses, radiographers and administrative and support staff totalling 32 personnel. We also spoke with 13 patients who were using the unit.

We observed care in the outpatient and imaging departments, in operating theatres and on the day case areas and reviewed 24 sets of patient records. We visited all the clinical areas at the unit.

Information about Cobham Day Surgery

Cobham Day Surgery unit is operated by Epsomedical Limited who also operates Epsom Day Surgery Unit. The two units are jointly managed with shared management, governance structures and staffing. Therefore, the provider does not always differentiate between the two locations when collecting and collating data. Throughout this report we have presented data specific to Cobham Day Surgery when possible, but some of the data we have used is that for Epsomedical Limited.

During the period April 2015 to March 2016, Cobham Day Surgery treated a total of 3,588 day case patients There were 18,456 outpatient attendances. Overall, about 99% of admissions and attendances were NHS funded.

In the same reporting period the most common procedures performed were gastroscopy (874) cataract surgery (538) and colonoscopy (287). The most active specialities in out-patients were dermatology (25% of total), ophthalmology (23%) and orthopaedics (16%).

At the time of our inspection, there were 70 doctors with practicing privileges at the unit, and 70% of these carried out over 100 procedures each during the period April 2015 to March 2016.; All those with practicing privileges carried out at least one procedure. Epsomedical Limited employed 16 whole time equivalent (WTE) registered nurses employed and five WTE operating department practitioners and health care assistants who worked across both the Cobham and Epsom units.

During the period April 2015 to March 2016 Epsomedical Limited received a total of six complaints. We did not receive any direct complaints or whistle-blowing contacts during this time. The Friends and Family test (FTT) score for NHS patients during the year 2015 -2016 was over 99% would recommend the unit.

During this period there were no deaths, serious incidents or never events at the unit. Never events are serious, largely preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. There were 13 other clinical incidents within this same period, five of these resulted in moderate harm and the remainder in no or low harm. The rate of clinical incidents in surgery, inpatients or other services (per 100 bed days) was below the rate of the other independent acute hospitals we hold this type of data for. There was one safeguarding concern reported and no reported cases of serious infection such as of meticillin-resistant staphylococcus aureus (MRSA) or instances of hospital acquired venous-thrombo-embolism (VTE) or pulmonary embolism (PE)

Endoscopy services at Epsomedical Limited were accredited by a national body and the service has Joint Advisory Group on GI endoscopy (JAG) accreditation.

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? Start here...	**Requires improvement** 
Are services effective? Start here...	**Good** 
Are services caring? Start here...	**Good** 
Are services responsive? Start here...	**Good** 
Are services well-led? Start here...	**Requires improvement** 

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	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	Good

Notes

Although some elements of the service required improvement, the overall standard of service provided outweighed those concerns. We have deviated from our usual aggregation of key question ratings to rate this service in a way that properly reflects our findings and avoids unfairness.

Requires improvement

Surgery

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

Information about the service

Cobham day surgery unit is part of Epsomedical Limited. It carries out a variety of different speciality surgery including minor orthopaedics, ophthalmic (eye), general, dermatology and gynaecology surgery. Endoscopy procedures are also undertaken in a dedicated endoscopy room.

The unit only treats adults aged 18 and over and does not provide services for children.

Between April 2015 and March 2016, there were 3,881 visits to theatre. The most common procedure undertaken during this period was gastroscopy (examination of the upper digestive tract). Gastroscopy accounted for 874, or 24% of all procedures. Cataract (clouding of the normally clear lens of eye) surgery was the second most commonly performed procedure and accounted for 538, or 14% of all procedures.

Patients do not stay overnight at the unit as it provides day surgery care only. The unit is open Monday to Friday between 7:30am and 8pm. Of all procedures performed between April 2015 and March 2016 98% were NHS funded and 2% were funded via non-NHS means.

The surgical treatment suite has a ward, one main operating theatre, a minor operation theatre (Shaylor theatre), a two bay recovery unit and an endoscopy room. The main theatre has laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination). A mixture of minor orthopaedic, gynaecology and general surgery is undertaken in this theatre. The Shaylor theatre undertakes procedures under local anaesthetic only, for example dermatology (skin) operations. Endoscopy procedures are undertaken in a dedicated room where decontamination facilities are incorporated. There is a ward area, which provides pre and post-operative care.

We visited all clinical areas including theatres, ward area and the endoscopy room during our inspection.

We spoke with 15 members of staff including nurses, doctors, allied health professionals, administrative staff and the executive team. We spoke with nine patients and one patient's relative. We also received 39 patient comment cards with feedback from patients who had undergone surgery at the unit. We reviewed 14 sets of patient records and a variety of unit data, for example meeting minutes, policies and performance data.

Requires improvement

Surgery

Summary of findings

We found surgical services were requires improvement for the key areas of safe and well led and good for effective, caring, and responsive. This was because:

- Equipment was not always available, maintained or checked including anaesthetic equipment.
- The systems to ensure the monitoring, storage and availability of medicines were insufficient.
- Some patients and staff were not aware of how to raise a concern or complaint.
- Leaders were not clear about their roles and their accountability for ensuring directors met the 'fit and proper person' regulation.
- There were concerns about the consistency and understanding that the management team had concerning the 'duty of candour' requirement.
- Staffing levels and skill mix were planned and reviewed to keep people safe at all times. All clinical areas had an appropriate skill mix.
- Staff knew the process for reporting and investigating incidents using the units reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
- Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. The unit monitored this to ensure consistency of practice.
- Feedback from patients was continually positive about the way staff treated people. We saw staff treated patients with dignity, respect and kindness during all interactions. Patients told us they felt safe, supported and cared for by staff
- Patient consent was recorded in line with relevant guidance and legislation.
- The unit had effective systems to assess and respond to patient risk and we saw examples during our inspection. There was a governance structure that promoted the delivery of high quality person-centred care.
- Leaders modelled and encouraged cooperative, supportive relationships among staff. We saw examples of good team working within the unit.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

By safe we mean that people are protected from abuse and avoidable harm.

We rated safe as requires improvement because:

- Anaesthetic equipment was not always available, maintained or checked including
- The systems to ensure the monitoring, storage and availability of medicines were insufficient.
- There were concerns about the consistency and understanding that the management team had concerning the 'duty of candour' requirement.

However;

- There were systems, processes and standard operating procedures for example in infection control that were reliable and kept patients safe.
- Staff told us openness and transparency about safety was encouraged. When something went wrong, there was an appropriate thorough review or investigation. This involved relevant staff and people who used services.
- We observed staff recognised and responded appropriately to changes in risks to patients who used services.
- We saw staffing levels and skill mix were planned, implemented and reviewed to keep patients' safe at all times. Any staff shortages were responded to quickly and adequately.
- The provider gave safeguarding sufficient priority and staff knew how to escalate safeguarding concerns.
- The provider had effective systems to assess and respond to patient risk.

Incidents

- The unit reported no never events between April 2015 and March 2016. Never events are serious, largely preventable patient safety incidents that should not occur if a unit has implemented the available preventative measures.
- The unit reported no deaths between April 2015 and March 2016 as there had been none. The unit reported no serious incidents between April 2015 and March 2016.
- Surgical services reported 10 clinical incidents between April 2015 and March 2016 and 77% of all unit wide clinical incidents related to surgical services. The assessed rate of clinical incidents (per 100 bed days) in surgery was below the rate of the other independent acute units that the CQC hold data for.
- Staff could all describe the process for reporting incidents, which was done via an electronic software system. Staff gave examples of times they had done this. All staff we spoke with had confidence in the incident reporting process.
- Staff told us the relevant ward or theatre manager fed back to the team with learning from incidents at monthly ward or theatre team meetings. We saw copies of the theatre team meeting minutes, which showed feedback and lessons learned from incidents were discussed. There was also a monthly management board newsletter sent from the management team, which also gave feedback regarding incidents.
- 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 notifiable safety incidents and to provide reasonable support to that person..

Safety thermometer or equivalent

- The safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to unit inpatients. These include falls, new pressure ulcers, catheter and urinary tract infections (UTIs) and venous thromboembolism (VTE) (blood clots in veins). The unit submitted data as part of this national programme.
- Between April 2015 and March 2016, the unit reported no incidents via the safety thermometer of VTE or pulmonary embolism. In the same time period, the unit reported no pressure ulcers or UTIs for catheterised inpatients.

Cleanliness, infection control and hygiene

Requires improvement

Surgery

- The provider reported no infections of meticillin-resistant staphylococcus aureus (MRSA), clostridium difficile or methicillin sensitive staphylococcus aureus between April 2015 and March 2016.
- We spoke with a pre-assessment nurse, who told us the unit screened and risk assessed all patients for MRSA. Only those considered high risk of carrying MRSA were swabbed, for example patients who have previously had MRSA**.** We saw in patients' records completed pre-operative questionnaires, which included completed risk assessments.
- The unit reported no surgical site infections (SSI's) between April 2015 and March 2016 as there had been no reportable incidents.
- We saw staff complying with infection prevention and control policies. For example, we saw six members of staff wash their hands and seven members of staff use alcohol hand sanitiser in accordance with the World Health Organisation (WHO) 'five moments for hand hygiene'. We saw hand sanitiser bottles readily available throughout clinical areas in theatres and on the wards. Hand hygiene audits in February 2016 showed 100% compliance.
- All members of staff we saw in clinical areas were bare below the elbows to prevent the spread of infections in accordance with national guidance.
- We observed that the National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection: Staff in the theatre environment followed prevention and treatment of surgical site infections (2008) was followed. This included skin preparation and management of the post-operative wound.
- Disinfection wipes were readily available for cleaning hard surfaces and equipment surfaces in between patients, and we witnessed staff using these.
- Waste in all clinical areas was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations.
- The clinical waste unit was secure and all clinical waste bins we checked were locked.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We checked 20 sharp bin containers and all were clearly labelled to ensure appropriate disposal and traceability.
- We saw posters displayed which outlined what action must be taken if a member of staff sustained a sharp injury; this information was also in departmental resource folders.
- We observed that sharp safe cannulas (a thin tube inserted into a vein) and sharp safe hypodermic needles (hollow needle) were being used. These devices reduced the risk of a member of staff receiving a sharps injury.
- An external contractor undertook the cleaning. We saw there was a communication diary, which was used to communicate with the domestic staff. Staff said they had a good relationship with the contractor and gave us an example of when the domestic staff had not been supplied with enough mops and the company was contacted and more were supplied.
- The domestic supervisor conducted regular audits to ensure the compliance to the cleaning schedules. The management team were sent copies of these in order to monitor compliance.
- Decontamination and sterilisation of instruments was managed in a dedicated facility offsite, which was compliant with the Medical Devices Directive. The facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres, ward and clinics.
- We saw water tests were undertaken and reported to the water committee in adherence with water management regime HTM 04-01. A full annual check and monthly tests were undertaken.
- In an infection control audit undertaken at Cobham Day Surgery in June 2016, the overall score achieved was 94%. This was better than the target score of 85%.The report also highlighted areas for improvement for example some of the equipment storage trolleys were dusty and one sharps bin had not been correctly assembled.
- The endoscopy area was self-contained in a dedicated room. It had separate clean and dirty utility areas and

was designed to facilitate flow from dirty to clean areas. This demonstrated adherence to the Health and Safety Executive (HSE) Standards and Recommended Practices for Endoscope Reprocessing Units, QPSD-D-005-2.2. However, the clean and dirty rooms did not have signs to demonstrate which room was clean and which one was dirty. This could cause confusion for staff that were not familiar with the environment.

- Staff transported dirty endoscopes from the procedure room to the dirty area in a covered, solid walled, leak proof container in line with HSE standards for endoscope reprocessing units.
- A clear decontamination pathway for endoscopes was demonstrated. There was an area where dirty scopes were passed through to the cleaning area. We saw there was a washing sink and a rinsing sink as well the washer machine. The wash machine was also able to carry out leak tests on the scopes. There were two drying cupboards and a storage cupboard for the endoscopes.
- Staff kept full scope tracking and traceability records. They indicated each stage of the decontamination process was occurring. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014). Testing of all washers was done on a daily basis. Filters were checked once a week. All equipment in the washing room was regularly serviced. Information about when the next service was due was available.
- We saw water sampling was undertaken from the final rinse cycle, which was tested for its microbiological quality at least weekly. This was in line with Health Technical Memorandum 01-06: Decontamination of flexible endoscopes.
- In the main operating theatre there was an anaesthetic breathing circuit attached to the anaesthetic machine, it was labelled last changed in May 2016.This contravenes the Association Anaesthetists of Great Britain and Ireland (AAGBI) Safety Guideline, Infection Control in Anaesthesia which states: “departments may follow the manufacturer’s recommendations for use for up to seven days”. We asked the theatre staff why this had not been changed and they said it had been overlooked. A senior member of staff went on to explain there was not a full time operating department practitioner (ODP) allocated to the unit to ensure such issues did not occur. This was an infection control risk as bacteria may have accumulated between May 2016 and September 2016.
- We observed staff cleaning equipment. However, it was not marked with a sticker to confirm this.There was no system that allowed staff to be immediately assured that equipment was clean at the point of care. However, we were shown cleaning checklists that showed theatre equipment was cleaned regularly.

Environment and equipment

- We saw in theatres and the wards staff had fully completed the trolley checklist throughout July and August 2016 providing evidence they had checked emergency equipment.
- In theatres, we observed staff checked all surgical instruments and gauze swabs before, during and at the end of patients’ operations. This was in line with the Association for Perioperative Practice (AfPP) guidelines.
- We checked over 30 consumable (disposable equipment) items and all were within date.
- The unit had an outside medical gas cylinder storage, which was compliant with The Department of Health (DOH) The Health Technical Memorandum (HTM)02-01 Part A guideline. This states medical gas cylinders should be kept in a purpose built cylinder store that should allow the cylinders to be kept dry, clean condition and secure enough to prevent theft and misuse.
- We inspected the gas manifold room that housed the piped medical gas supply. The room was located at the back of the building. Appropriate signage was in place to notify people what was contained within. The room was locked and this prevented any potential sabotage to the supply of medical gases.
- We saw there were an adequate number of portable oxygen cylinders for the transfer of patients or for use in an emergency. We checked six cylinders, which were in date and labelled.
- We spoke to the unit engineer who told us that there was a unit generator that was tested monthly; this ensured there was a backup supply of electricity if the main electricity supply failed.

- The staff we spoke with confirmed they had access to the equipment they required to meet peoples' care needs.
- There were two collections and deliveries of instruments a day in theatres. In addition, an instrumentation co-ordinator ensured relevant equipment was available. This meant the coordinator was able to organise availability of equipment, which ensured patients were not delayed or cancelled due to the unavailability of equipment.
- The endoscopy equipment was newly purchased within the last year. We saw staff received certificates when they had completed comprehensive training on using this equipment. In addition, a list of staff who had undertaken the training was kept in a folder with the equipment.
- We saw there was not a specific difficult intubation trolley, which contained specialist equipment for use in a difficult airway. This contravened The Association of Anaesthetists of Great Britain and Ireland (AAGBI) in their Safety Guideline – Checking Anaesthetic Equipment 2012 states "equipment for the management of the anticipated or unexpected difficult airway must be available and checked regularly in accordance with departmental policies." We asked staff why there was not a trolley available and they explained they just kept a few pieces of specialist equipment and this was done on the advice of the clinical governance anaesthetist. This meant equipment might not be available and easily accessible in an emergency.
- We saw that electrical safety checking labels were attached to electrical items showing they had been tested and was safe to use. We checked 15 electrical items and we could not find evidence of an electrical safety check on two pieces of equipment. However, the rest had undergone electrical testing within the last year. We were unable to find evidence of the last electrical safety check on the defibrillator and emergency suction unit. This meant the function and safety of this equipment could not be assured. We asked a member of staff about why this was and their response was "not my area". We escalated this to the management team who assured us they would arrange testing. The management team explained the unit was in the process of creating an electronic equipment asset register. This would allow the unit to identify each piece of equipment in use and associated servicing records.
- We checked 16 items on the emergency trolley and all were in date. However, there was six items, which had been removed from their original packaging and were no longer sterile. This contravened the Association Anaesthetists of Great Britain and Ireland (AAGBI) Safety Guideline, Infection Control in Anaesthesia, which states: "Packaging should not be removed until the point of use for infection control, identification, traceability in the case of a manufacturer's recall, and safety".
- In the main theatre, we reviewed the anaesthetic machine logbooks for the anaesthetic machine. We saw staff had not fully completed both logbooks with evidence of daily pre-use checks in accordance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. This did not provide assurance that the anaesthetic machines worked safely. We spoke to one of the senior operating department practitioners regarding the lapses in the checking process; they said this was because the anaesthetic machine was not used on that day. The guidelines state logbooks should be documented concurrently and on days when the machine was not used it must be documented in the logbook.

Medicines

- The unit did not have their own pharmacy on site. They had a service level agreement (SLA) with the local NHS trust, which supplied all medicines and advised regarding pharmacy matters, which we reviewed. We reviewed the SLA agreement and noted that the agreement had been signed by the NHS trust in March 2016 but not signed by the management team within the unit until July 2016.This meant there was a gap of four months when there was a lapse in the agreement.
- Medicines were ordered on a Monday by a senior member of staff and were delivered on Wednesdays. There was a dedicated car and driver employed by the unit to manage the transportation of medications.
- We saw on the wards that medicines were stored safely and securely in line with relevant legislation for the safe storage of medicines. However during our inspection a

health care assistant (HCA) in endoscopy had possession of the keys to the controlled drugs cupboard. This contravened Epsomedical Limited Cobham Day Surgery Unit Policy on Drugs and Medicines which stated," The keys are only to be held by regular nurses or operating department practitioners authorised by the senior registered nurse".

- We checked temperature monitoring charts for the medicine fridges in both theatres and the endoscopy room. The records showed staff had monitored the temperature of both fridges daily in the last month. We asked two members of staff, and both knew the safe temperature ranges for the fridge and at what temperatures they should take action. This provided assurance the unit stored refrigerated medicines within the correct temperature range to maintain their function and safety.
- There was a completed daily checklist for monitoring the ambient temperature in the theatres, and endoscopy room. This ensured medicines stored at room temperature remained within the manufacturer's indicated temperature range.
- Prescriptions were generated electronically; a summary of medicines given during an operation was contained within the anaesthetic record, which was printed at the end of the procedure. This ensured staff knew what medicines had been administered in theatres. Standard medicines that may be required after surgery were electronically prescribed by the surgeon or anaesthetist to ensure they could be administered quickly if required, for example pain relief.
- Patient allergies had been clearly noted on their paper notes and on their identity band, which alerted staff to their allergy.
- Blank prescriptions were stored in a locked drawer of the computer printer. This was in line with guidance from NHS Protect. Blank prescriptions were available in an emergency and were kept securely and we saw one used during our inspection.
- There was a medicine trolley in the main theatre, which contained anaesthetic medicines. This trolley had a keypad lock to ensure the security of the drugs.
- Staff told us that if they needed advice regarding a medication, they rang the pharmacy department at the NHS unit or they accessed the British National Formulary (BNF).
- We saw a medicine cupboard in the endoscopy room with a faulty lock, we alerted staff to the issue and it was repaired immediately.
- We checked the controlled drugs (CD) cupboards. Controlled drugs are medicines liable for misuse that required special management. We saw the CD cupboards were locked, and we checked a random sample of stock levels. We saw the correct quantities in stock according to the stock list, and that all were in-date. However all the CD books demonstrated incomplete records of the CD's. This was because staff blanket-signed for the drugs rather than signing individually at each stage of the dispensary process. In some cases, there was only a scribble and not a signature. We asked a senior member of staff if this had been identified as an issue previously and they said it had not been. This meant it would not be easy to identify the person who had administered or witnessed the administration of the drug. We checked the signature register and there was not a signature or a similar one on record that matched the illegible signature in the CD register. The provider subsequently informed us that all signatures of personnel working at Epsomedical are electronically stored on the relevant file, although we have not had the opportunity to test this.
- We saw there was a pharmacy stock list, displayed near the staff base. However, staff told us they did not follow this and just ordered on a top up basis on whichever medications were running low. This meant accurate medicine reconciliation records and processes could not be assured, as the unit did not monitor stock levels or usage of drugs. During our inspection, we saw an example of the result of a failure in this process. A patient was prescribed a medication to take after the operation, which would normally be supplied to the patient on discharge from the unit. It had however gone unnoticed that there was none of this medication available in the unit. In this instance, that patient was given a prescription to take to a pharmacy to obtain the medication.

- We found a plastic basket in a medicine trolley in the main theatre that contained strips of medications including tramadol. Medications should be kept in their original packaging so the expiry date and batch number could be identified. We asked the senior nurse about the basket but she said that she had not seen it before and could not account for it.She assured us that she would take action to address the issue. However, when we returned to the unit the following day the basket was still present in the medicine trolley. This meant action had not been taken to ensure patients did not receive out of date medicines.

Records

- There was an electronic patient record (EPR) system in use at Cobham Day Surgery Unit, and there were minimal paper records. The system was still quite new and different elements had been added during a suitable time period. It was a live record, which captured the patient's journey from the booking of their procedure to discharge after their procedure. This meant at any point staff where able to access the system and identify where the patient was in their treatment pathway.
- Staff described being apprehensive about the system to start with; however all felt they had received an adequate amount of support and training. Staff were able to demonstrate the system quickly and easily to us, for example, where the patient's venous thromboembolism (VTE) assessment was located.
- Some of the patient records were paper based on the day of admission for example their pre-operative checks, consent form, standardised care plans and the World Health Organisation 'five steps to safer surgery' checklist. This ensured during the time the patient was admitted relevant information stayed with the patient and was easily accessible. Staff told us after the patient had been discharged these documents were scanned into the EPR system and the papers shredded.
- The paper records were kept securely at the staff station, which was in constant sight of staff. This maintained the security and prevented unauthorised access of patient records.
- Patients completed a paper based pre-assessment questionnaire and the information was transferred to the EPR.
- We saw the theatre records section of care plans were clear and documented checks to ensure safe surgery and treatment was undertaken.
- There was a records audit undertaken by the provider between April 2016 and June 2016 which demonstrated 100% compliance in day surgery.

Safeguarding

- There was one safeguarding concern reported to CQC in the reporting period (April 2015 to March 2016) as a statutory notification.
- Safeguarding policies and procedures were in place to ensure that staff understood their responsibilities to protect vulnerable adults and children. The unit compliance manager and the medical director were jointly responsible for leading on all safeguarding for the unit.
- Safeguarding training was part of staff mandatory training. Training records showed 100% of clinical staff had completed safeguarding adults training and 96% had completed safeguarding children. This was better than the unit target of 85%. Administrative staff had completed safeguarding children training 89%, which was better than the unit target of 85% and safeguarding adults 81% which was worse than the unit target of 85%.The data provided was Epsomedical Limited (Epsom Day Surgery and Cobham Day Surgery) wide and not site or speciality specific.
- There were flow charts in each department detailing the actions to be taken and who to contact in the event of adult safeguarding issues arising. Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures.

Mandatory training

- Mandatory training was outsourced to external agency all mandatory training was undertaken in one day on a face-to-face basis. The training included infection control and prevention, information governance, equality and diversity, vulnerable adults, manual handling and fire safety.
- Consultants and clinicians with practising privileges were not required to complete training via the unit system but the medical advisory committee checked assurance of mandatory training. The registered

manager told us if doctors were not up to date with mandatory training, and did not provide current and valid practice certificates, they were suspended from practice until the training was renewed and evidenced.

- We saw the training records for staff, which were included within their appraisal (excluding medical staff) for mandatory training. This showed nearly 98% of clinical staff were compliant with mandatory training which was better than the unit target of 85%. This data was only available for the provider overall and was not site, or service specific.
- All staff underwent an induction programme specific to their area of work. This included a tour of the facilities and teams, clinical supervision and protected time for reading the relevant policies and protocols. The induction course was written using a standard template, signed off on completion by the responsible manager and filed in the employee's personnel record.

Assessing and responding to patient risk

- Patients' risks were assessed and monitored at pre-assessment, and checked again before treatment. These included risks about mobility, medical history, skin damage and venous thromboembolism (VTE)
- The unit did not have any level two or three critical care beds. To mitigate this risk, the unit only operated on patients pre-assessed as grade one or two under The American Society of Anaesthesiologists (ASA) grading system. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma.
- Patients completed a preadmission questionnaire to assess if there were any health risks, which may compromise their treatment at the unit. Nurses discussed the health questionnaires with patients in the pre-admission clinics or via the telephone. If staff identified a patient as being at risk, they were not accepted for surgery.
- Staff met for a team briefing at the start of each operating list in accordance with the World Health Organisation 'Five steps to safer surgery'. We observed a team briefing, which was comprehensive and discussed each patient to minimise any potential risk to patients. Pre-existing medical conditions and allergies were discussed to ensure the team was informed. Equipment requirements were also discussed and in particular, a member of theatre staff highlighted that some emergency equipment had gone for reprocessing. It was agreed by the team that the operation at the greatest risk of requiring this instrumentation would not start until the equipment was available. In addition, the surgeon confirmed with the theatre staff that they had received training on a new piece of equipment that was going to be used prior to the operating list starting. The briefing demonstrated that risks were discussed and any potential issues were highlighted.
- The unit used the Modified Early Warning System (MEWS) track and trigger flow charts. MEWS was a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support. We reviewed six patients' MEWS charts. Staff had completed all six accurately and fully.
- The provider had an unplanned transfer's policy which was in date. The policy set out what action should be taken if a patient became unwell and required transfer to an acute hospital.
- The provider reported no unplanned transfers of an inpatient to another unit in the reporting period (April 2015 to March 2016).
- We saw all patients had a VTE assessment completed and all patients wore anti-embolic stockings. The purpose of anti-embolism stockings is to reduce a person's risk of developing venous thromboembolism. The unit consistently met their NHS contracted 95% target screening rate for VTE risk assessment between April 2015 and March 2016.
- Ward nurses staff told us they checked the pregnancy status of female patients of potential childbearing age on the morning of planned surgery by undertaking a pregnancy test. We saw the results of the test were documented on pre-operation checklist.
- We observed theatre staff carrying out the World Health Organisation (WHO) 'five steps to safer surgery' checklist for procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before

anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre).We saw staff fully completed all the required checks at the correct time and staff were fully engaged in the process.

- We reviewed four completed WHO checklists and all were fully completed. This meant there was assurance that the safety checks had been completed.
- We observed staff using specific WHO checklists for different procedures, for example endoscopy. This ensured staff checked the most important safety factors relating to a specific procedure.
- We saw there were a variety of risk assessments used, for example infection control risk assessments and patient pressure area assessments.
- All patients who underwent a general anaesthetic received a follow up phone call between 24-72 hours after discharge. The unit undertook an audit of follow up phone calls between April 2015 and April 2016, patients were asked specific questions and the answers were logged into the computer system. In total 395 patients underwent a general anaesthetic and were telephoned. The results of this audit showed 31% of patients were not able to be contactable, of the remaining 69%, 4% of patients reported a problem or concern. The highest proportion of patients who experienced post-operative problems, were patients who underwent gynaecological procedures (1.3%)

Nursing staffing

- Epsomedical Limited (Epsom Day Surgery and Cobham Day Surgery) surgical departments had 21 whole time equivalent (WTE) nursing staff; of these 16 WTE were registered nurses and five were health care assistants (HCA's) and operating department practitioners. These staff numbers were for both sites as staff worked across the Cobham and Epsom sites.
- There was one registered nurse vacancy and one operating department practitioner vacancy.
- On the day of our visit, we saw staffing levels met the AfPP guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list.
- The Royal College of Nursing (RCN) recommends a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse (RN) for eight patients; surgical services were compliant with this. We saw on the ward the nurse to patient ratios varied between1:5 and 1:6, this was better than the RCN recommendations.
- The use of bank and agency nurses, operating department practitioners and HCA's made up a combined total of 20% of all hours worked of the three staff groups across both hospital sites.
- Staffing levels were calculated on electronic eight week timetable, then checked and adjusted daily depending on changes and or patient requirements. We saw staffing levels were reviewed at team briefings to ensure there was the correct level of staff.
- We saw staff worked flexibly, and saw the management team working clinically to support their colleagues when an overrun of a theatre list occurred.

Surgical staffing

- The unit told us they had 70 consultants working with agreed practice privileges. This related to consultants in post at 1 April 2016 with more than 12 months service. The granting of practicing privileges is an established process whereby a medical practitioner is given permission to work within the independent sector. We reviewed a sample of practicing privileges agreements and found them to be current and up to date. All consultants maintained registration with the General Medical Council and were on the specialist register.
- There was an Epsomedical Limited practicing privileges policy. We saw all medical staff had been fully trained to undertake procedures, which they regularly performed within their NHS practice. The medical director was responsible for the granting and revoking of practicing privileges.
- A member of the nursing staff told us medical cover was good and consultants were always obtainable, and would return to seepatients if necessary. There was not always a surgeon or anaesthetist on site and staff contacted consultants via telephone if advice or help was required. Staff told us both the surgeon and anaesthetist would check that they were happy with the patient's condition prior to leaving the unit.

Major incident awareness and training

Requires improvement

Surgery

- A unit-wide fire alarm test took place on a weekly basis and staff knew when this was planned.
- Epsomedical Limited had a disaster handling and business continuity plan. The plan was designed to enable the unit to overcome any unexpected disaster to its premises, key personnel or to any important systems relied upon in day-to-day operations. The plan had lists of contacts and action plans. Staff told us this plan was easily accessible on the computer.
- The unit had a back-up generator to ensure services could continue in the event of a disruption to the main power supply. Maintenance staff told us the generator was checked on a monthly basis, generator testing provided the unit with assurance that the generator would provide back-up power and enable services to continue in the event of a power failure.

Are surgery services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because

- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. There were processes in place to update policies and procedures.
- Patients had comprehensive assessments of their needs and their care and treatment was regularly reviewed and updated.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff were also supported to maintain and further develop their professional skills and experience.
- Staff obtained and recorded consent in line with relevant guidance and legislation.
- Staff had completed training about the Mental Capacity Act; they could demonstrate a clear understanding of the procedures to follow for patients who lacked capacity to make decisions for themselves.

Evidence-based care and treatment

- Patient care and treatment reflected current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines.
- In theatres, and in the patient notes, we saw evidence of the unit providing surgery in line with local policies and national guidelines such as NICE guideline CG74: Surgical site infections: prevention and treatment. For example, in theatre we saw that the patient's skin was prepared at the surgical site immediately before incision using an antiseptic liquid.
- We reviewed three patient records, which all showed, evidence of regular observations, for example, blood pressure and oxygen saturation, to monitor the patient's health post-surgery. Staff had completed all three observation charts in line with NICE guideline CG50: Acutely ill patients in unit- recognising and responding to deterioration.
- In addition, the modified early warning system (MEWS) was used to assess and respond to any change in a patients' condition. This was also in line with NICE clinical guideline CG50.
- Venous thromboembolism (VTE) assessments were completed at pre assessment and re assessed on admission in accordance with NICE clinical guideline CG92 'reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to unit.
- Patients' temperatures were measured and documented in accordance with inadvertent perioperative hypothermia, NICE guidance clinical guideline CG 65.
- Policies, procedures and working practices were based on guidance from national organisations to ensure compliance with clinical standards and recommendations. For example, we reviewed the unit policy: Guidelines for the nurse/ODP/assistant theatre practitioner when acting as a scrub practitioner/surgical first assistant. This policy referenced the "Position statement: Surgical First Assistant (the Perioperative Care Collaborative 2012)." There were specialist clinical

pathways and protocols for the care of patients undergoing different surgical procedures. For example eye surgery pathway, these were designed to specifically assess risks associated with these procedures.

- A senior member of staff explained how they were in the process of reviewing all unit policies and procedures in line with National Safety Standards for Invasive Procedures (NatSSIPs). The principle behind the NatSSIPs is that organisations will review their current local processes for invasive procedures and ensure that they are compliant with the new national standards.
- Adherence to policies and national guidelines was discussed at management and departmental meetings to ensure care and treatment offered was up to date. For example we saw in the meeting minutes of the clinical staff in October 2015 that the decontamination policy had been updated and staff were asked to read it and familiarise themselves with it.

Pain relief

- The pre assessment lead told us patients were counselled on pain management as part of the pre assessment process. Patients we spoke to confirmed different pain relief had been discussed at pre assessment. In addition, patients confirmed take home pain relief medicines were also discussed. This meant patients were informed regarding pain relief prior to their procedure.
- We spoke to four patients who had recently undergone surgery. All told, us their pain was well controlled and said nurses responded quickly when they requested additional pain relief.
- We saw potent pain relief was prescribed for the immediate post-operative period when the patient was in recovery. This meant if a patient woke up from the anaesthetic and experienced pain it could be administered to the patient quickly rather than it having to be prescribed.
- A recognised pain assessment tool was used, patients were asked to rate their pain between one and 10, one meaning no pain and 10 being extreme pain.
- Information regarding feedback on pain relief was gathered in post-operative telephone calls. An audit was undertaken regarding post-operative follow up phone calls between April 2015 and April 2016. One of the questions in the audit asked if patients experienced pain after discharge from the unit. The audit showed out of 395 patients in the audit no patients reported problems with pain. This demonstrated that patients were provided with adequate pain relief after discharge.
- Patients were also asked as part of the endoscopy survey if they felt that their pain relief was adequate. In an endoscopy audit undertaken by the unit in April 2016, 93% of patients reported they were given adequate pain relief during their procedure.
- We saw records which showed that staff used a pain scale to assess patient' pain and to evaluate the effect of any pain relief given.

Nutrition and hydration

- There was a robust process in place to ensure patients were appropriately starved prior to undergoing a general anaesthetic, each patient was asked to confirm when they last ate and drank during the checking process on arrival to theatre. The amount of time patients were kept nil by mouth prior to their operation was kept to a minimum, patients were allowed to drink clear fluids up to two hours prior to their operation and patients having operations in the afternoon had an early breakfast, this was in line with best practice.
- The unit offered hot drinks, water and biscuits to patients before discharge home.

Patient outcomes

- There was one unplanned readmission within 28 days of discharge in the reporting period (April 2015 to March 2016). The assessed rate of unplanned readmissions (per 100 inpatient attendances) was not high when compared to a group of independent acute units, which the CQC hold data for.
- There was one unplanned return to the operating theatre for the same time period.
- The unit participated in the national Patient Reported Outcome Measures (PROMS) audit for varicose vein and hernia procedures. PROMS measures the quality of care and health gain received from the patient's perspective.
- PROMS data was collated and submitted by a third party company. The provider told us that they discovered earlier this year that PROMS data was not being correctly processed by the Health and Social Care

Information Centre(HSCIC). The provider believed the problem to be resolved and anticipated having performance data available from quarter two or three 2016/17.

- Data was also submitted to the Global Rating Scale as part of Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.
- We reviewed the JAG data submitted between October 2015 and March 2016.The data demonstrated good patient outcomes. For example there was a 99% successful intubation (insertion of flexible camera into the stomach). In addition 97% of patients had good or satisfactory bowel preparation (medicine taken to clean the bowel in order to thoroughly examine the bowel).
- Performance was monitored by submitting data to the Secondary Uses Service and Monthly Activity Returns portals as well as to the bespoke Clinical Commissioning Group's (CCG's) scorecard. This measured performance against key performance indicators.
- Epsomedical Limited undertook and audit in 2015 which reviewed cataract (a medical condition in which the lens of the eye becomes progressively opaque, resulting in blurred vision) surgery complication rates. The results of the audit showed out of 949 cases undertaken 1.26% of patients suffered complications, this was the same rate as the national average rate of 1-2%.This demonstrated that complication rates were in line with the national average.
- The Manchester-Oxford Foot Questionnaire (MOXFQ) is a 16-item Patient Reported Outcome (PRO) measure developed and validated for use in studies assessing outcome following foot and/or ankle corrective surgery. Between October 2015 and April 2016 Epsomedical Limited asked patients across both sites to complete the MOXFQ questionnaire. The questionnaire covered three domains which asked patients about pain, walking and social interaction. Patients were asked about the three domains prior to and post-surgery. The audit showed that the average patient score for pain was 31 pre surgery and 15 after surgery, the average patient score for walking was nine pre surgery and four post-surgery and the average patient score for social interaction was 10 pre surgery and four post-surgery. This audit demonstrated that there was an improvement in the patients' symptoms post-surgery.

Competent staff

- All new staff underwent an induction, which included a departmental orientation programme. As part of this process, staff were allocated a mentor who was a senior member of staff. We saw records for a member of staff working in endoscopy and they confirmed they had been allocated a mentor.
- Agency and bank nurses received orientation and induction to the ward area and we saw examples of completed induction documents.
- Ward and theatre staff confirmed that appraisals took place and staff told us they had received an annual appraisal. Records showed 100% of staff had had an appraisal in 2015, however all staff were yet to undergo an appraisal in 2016. Senior staff told us there was a programme to ensure appraisals were undertaken. We heard that the staff thought the appraisal system was effective as it formalised individual competencies and identified training needs for the next year. We also saw that the appraisals process incorporated progress reviews throughout the year.
- There was a system to ensure qualified doctors and nurses' registration status had been renewed on an annual basis. Data provided to us by the unit showed a 100% completion rate of verification of registration for all staff groups working in the ward and theatres.
- The unit undertook robust procedures, which ensured surgeons who worked under practising privileges, had the necessary skills and competencies and that surgeons received supervision and appraisals. The management team ensured the relevant checks against professional registers, and information from the Disclosure and Barring Service (DBS) were completed.
- Any clinical practice concerns arising in relation to a consultant were discussed at the Medical Advisory Committee meetings; we saw evidence of this in meeting minutes. We saw detailed records that demonstrated that appropriate action had been taken when consultant's practice, shown through outcome data, had caused concern.

- The unit provided data that demonstrated that no doctors had their practising privileges suspended between April 2015 and March 2016.
- We saw staff in theatre underwent 'clinical sign off' of interventions undertaken during operations.
- Staff were required to be supervised 10 times to perform a task before they could practice without supervision, for example holding the operating camera during surgery.
- Two members of staff had undertaken accredited first assistant training, meaning they were qualified to assistant the surgeon. We reviewed a local policy: Guidelines for the nurse/ODP/assistant theatre practitioner when acting as a scrub practitioner/surgical first assistant. This policy set out a clear list of duties that could be undertaken by theatre staff. This meant that practitioners had received the appropriate level of training and supervision to carry out tasks safely. In addition, practitioners were only undertaking duties that were covered within the unit's policy.

Multidisciplinary working (in relation to this core service only)

- The surgical service demonstrated multidisciplinary teamwork with, comprehensive record keeping and good communication. Patients' individual needs were considered during pre-admission discussions, with treatments planned accordingly.
- We saw that medical staff, nursing staff and the management worked on the ward. Staff told us that the management team was 'clinically credible' and would work clinically when required.
- We observed their 'daily team briefing', which was held each morning for all theatre staff to review the operating lists, and day ahead. This was also attended by a ward representative to ensure affective communication within the whole department.
- The unit liaised with district nurses to arrange ongoing care for patients post-discharge where appropriate. We saw there were contact details of district nurses and GP's so they could be easily contacted if required.

Seven-day services

- Cobham Day Surgery was open Monday to Friday between the hours of 7:30am and 7pm. Patients were given details of whom to contact outside these hours should they have any questions or experience any problems.

Access to information

- The unit used a comprehensive computer software system; this allowed access to all aspects of patients care from booking to discharge. Staff had different levels of access to the system dependent on their job role.
- Staff used a personal access card, which allowed access to the system and prevented unauthorised access.
- Discharge summaries were sent electronically to GPs when patients were discharged from the unit. We observed the discharge process and saw care and discharge summaries were also given to patients on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The unit had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- We reviewed four consent forms for surgery. Patients and staff had fully completed, signed and dated the consents to ensure they were valid.
- The consent forms did not contain any abbreviations that a patient may not have understood. One of the consent forms included percentage rates of different complications relating to the patient's procedure. This showed staff had fully informed patients of the possible risks and obtained informed consent.
- In an endoscopy audit undertaken by the unit in April 2016, ninety five per cent of patients felt they were given enough information about their procedure and 100% of patients felt they had enough time to read through their consent form before signing it.
- Staff told us they very rarely saw patients who may lack capacity to make an informed decision about surgery. We spoke with staff about informed consent and they were clear about the procedures to follow for patients who lacked capacity to make decisions for themselves.

- Staff were aware of Deprivation of Liberty Safeguards however, staff on the ward told us they had never needed to apply them.

Are surgery services caring?

Good

We rated caring as good because:

- Feedback we received from patients and people, those who are close to them and stakeholders was positive.
- Patients were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.
- Staff anticipated patients' needs and their privacy and confidentiality were respected at all times.
- Patients understood their care, treatment and condition. Patients and staff worked together to plan care and there was shared decision-making about care and treatment.

Compassionate care

- The unit's friends and family test (FFT) score was 99% for NHS patients in the 2015/16 survey. There was no breakdown of the figures therefore; it was not possible to identify the significance of these statistics about the surgical services.
- We observed compassionate and caring interactions from all staff. Patients were positive about the care and treatment they received.
- We saw people treated as individuals and staff spoke to patients in a kind and sensitive manner. Staff were friendly, polite respectful and courteous.
- There were 13 thank you cards displayed in the unit, which contained comments from patients about their experiences of care.
- We saw that staff always respected patients' privacy and dignity. We saw staff in recovery closing the curtains around patients in recovery to protect their privacy. In addition, there were signs saying, "patients in recovery please keep noise to a minimum" This demonstrated consideration was given to patients who were recovering from surgery.
- We received 39 patient comment cards from patients who recently had surgery at the unit. We reviewed these comment cards and all were positive. Positive comments on the cards included:" The staff were very caring, very welcoming, introduced themselves and put me at ease straight away" and "Wonderful service with extremely caring staff".
- Epsomedical Limited undertook an endoscopy patient satisfaction survey across both sites in April 2016, this survey showed that 100% of patients felt an effort was made to respect their privacy and dignity and 96% of patients said their clinical care was discussed in private. This demonstrated that patients' dignity, respect and confidentiality was maintained.

Understanding and involvement of patients and those close to them

- Patient comment cards stated "Staff were very friendly made you feel at ease" and "Everything has been explained in great detail".
- These comments reflected patient centred care and patient individual needs were taken into consideration.
- We spoke to nine patients, who all told us they had been kept well informed at every stage of their care.
- The service involved patients' relatives and people close to them in their care. Staff told us how they took time to explain to patients and their relatives on how to wash their face if they had undergone surgery on the face. There was a variety of aftercare information leaflets available that relatives or carer's could read and refer to if required. This ensured patients received the correct post-operative care.
- All patients we spoke with felt staff had given them sufficient information about their procedure, and were able to discuss it with their consultant and nursing staff. Staff gave patients information about their procedure at pre-assessment.
- Staff discussed their care in detail and explained what to expect post-operatively. Ward staff gave patients a discharge pack with specific post-operative instructions.

Emotional support

- Sufficient time was allocated for the pre- assessment appointment to allow patients time to discuss any fears or anxieties.

- We saw staff in theatres providing emotional support to patients who were worried or anxious.
- Epsomedical Limited undertook an endoscopy patient satisfaction survey across both sites in April 2016, 98% of patients answered that they felt supported whilst in theatre.
- There were notices on walls in the unit, which gave information regarding a variety of local support groups.

Are surgery services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good because:

- The provider planned and delivered services in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service.
- Facilities and premises were appropriate for the services being delivered.
- Complaints and concerns were always taken seriously, responded to in a timely way and listened to.
- The service made reasonable adjustments and took action to remove barriers for people who found it hard to use or access services.

Service planning and delivery to meet the needs of local people

- The unit worked with the local Clinical Commissioning Group's (CCG's) in planning services for NHS patients. The unit provided elective surgery mainly to NHS patients for a variety of specialities, which included; ophthalmology, general surgery, gynaecology and general surgery. This meant local people had a choice about where they received their care and treatment.
- All admissions were pre-planned so staff could assess patients' needs before treatment. This allowed staff to plan patients' care to meet their specific requirements, for example physical needs.
- The senior staff in theatres reviewed operating lists in advance. This ensured there was sufficient time to arrange all the necessary staff and equipment.
- We saw the theatre and ward facilities were appropriate for the services provided and met the needs of the local community.
- Specific procedures for example patients undergoing endoscopy were separated by gender, females would undergo procedure on one day and males another day. This was to ensure compliance with the Department of Health's same-sex accommodation guidance.
- GP's were able to access waiting times at the unit via the computer system, and inform their patients of these so they could plan their care and treatment.

Access and flow

- On arrival at the unit, patients booked in at reception and this was reflected on the computer system so staff working on the ward knew when patients arrived. When the ward staff were ready to admit the patient they were collected from the reception and taken to a bed space on the ward. Pre- admission checks and assessments were undertaken, when complete the patient changed and waited for their procedure in the waiting room. Staff then escorted patients to the theatre or endoscopy room for their procedures. The majority of patients walked to theatre rather than going on a trolley or wheelchair. Immediately after surgery, staff cared for patients in the recovery room.
- Once patients were stable and pain-free, staff took them back to the ward area to continue recovering. Patients had a responsible adult to collect, escort and stay with them for 24 hours. We saw in the patients care plan there was a section that must be completed with the nominated adult's name and contact details. This ensured staff were aware who to contact when the patient was fit for discharge and who would stay with them for 24 hours.
- The provider reported they cancelled 48 procedures for a non-clinical reason in the last 12 months; of these 100% were offered another appointment within 28 days of the cancelled appointment in line with Department of Health guidance.
- Epsomedical Limited (Epsom Day Surgery and Cobham Day Surgery) met the target of 92% referral to treatment

(RTT) waiting times for patients beginning treatment within 18 weeks of referral for each month in the reporting period April 2015 to March 2016. The provider did not supply site specific data because RTT's were managed across both sites.

- Between April 2015 and March 2016 Epsomedical Limited (Epsom Day Surgery and Cobham Day Surgery) demonstrated a strong performance in RTT as well as diagnostic and cancer waiting times. These results were discussed at the quarterly clinical quality review meetings with the main commissioner. The unit benchmarked performance against comparative data from local NHS trusts. National and local targets were set out by the CCG's and provided a clear framework of expectations and progress. For example, the unit submits monthly scorecard data to the CCG's. We reviewed this data, which demonstrated that between April 2015 and March 2016, 99% of patients had their first outpatient attendance within two weeks from urgent referral from their GP. In addition, in the same time period, 100% of patients had their first definitive treatment from the decision to treat within 31 days. This demonstrated that patients were able to access timely treatment.
- Epsomedical Limited had a patient pathway from referral to discharge this was a computer based system. Referrals were received by the schedulers in medical records and were triaged by the clinical director or the compliance manager. The scheduler booked patients into the appropriate clinic using an eight week roster system and ensured the relevant diagnostic tests would be available on that day. If patients required surgery, dates for surgery were discussed with patients at their initial outpatients' appointment.
- All of the patients we spoke with told us they had short waits for their surgery.

Meeting people's individual needs

- Pre-assessment was used effectively to ensure the unit only treated patients if they could meet their needs. The pre-assessment nurse confirmed that all patients were pre-assessed for surgery in advance.
- Staff told us the unit could book interpreters for patients. Patient information leaflets could be printed from a database in different languages.
- Staff told us that patients living with learning difficulties or additional needs were highlighted at the pre assessment stage. The purpose of this was to alert clinical staff to the patient's individual needs. This allowed staff to plan effectively, for example by arranging theatre lists in a way that lessened anxiety for patients living with learning disabilities. For example staff explained how a patient living with dementia underwent a procedure under local anaesthetic and they had their surgery scheduled first on the list in order to minimise waiting time.
- The unit had lift access to the first floor and wide access for patients using a wheelchair or mobility aids.
- For patients' with hearing loss, a hearing loop was provided in the main reception of the unit.
- We were told that should a patient require the support of a carer or a family member they were encouraged to stay at the unit to offer familiar assurances.
- We saw staff in recovery asking patients if they were warm enough and offering them sips of water to ensure they were comfortable.

Learning from complaints and concerns

- The unit had an up to date complaints policy with a clear process to investigate, report and learn from a complaint. Complaints could be made verbally or in writing directly to the organisation, via their website or by NHS choices. Complaints were centrally logged by the compliance manager who oversaw the investigation.
- Epsomedical Limited complaints policy set out the relevant timeframes associated with the various parts of the complaint response process. An initial acknowledgement was required within two working days and a full response within 20 working days. If a complaint was escalated to a further stage, the complainant was be given the information of how to escalate the complaint and to whom if they remained unhappy with the outcome.
- All complaints were discussed at monthly management board meetings and Medical Advisory Committee (MAC) meetings where the nature, response and outcome of the complaint were reviewed.

Requires improvement

Surgery

- Staff received feedback regarding complaints via the team departmental meetings and on an individual basis when staff members were involved in the investigation.
- Information on how to make a complaint was available in leaflet form and on the organisation's website. We saw there were leaflets and posters displayed in the unit which detailed how to make a complaint.
- We reviewed five complaints; these demonstrated that patients had been acknowledged appropriately, investigated and patients were agreed of the outcome within the specified time frames unless agreed otherwise with the complainant.
- CQC directly received one complaint in the reporting period (April 2015 to March 2016). This was in September 2015.
- The unit had six complaints in the reporting period April 2015 to March 2016. No complaints had been referred to the ombudsman or an independent adjudicator. The assessed rate of complaints (per 100 inpatient and day case attendances) was below the rate of other independent acute units CQC hold data for.
- Three of the complaints related to surgical services, staff were able to give us examples of complaints and resolutions. For example, a patient who was deaf complained because there was not a hearing loop installed, because of this, the unit installed one.
- We asked patients and staff if they were aware of the process if they wanted to make a complaint regarding the care they had received. Not all of the staff and patients were clear on what action to take. This meant staff may not know how to direct patients through the correct process and patients may be reluctant to make a complaint because they did not know how to.

Are surgery services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led in surgery as requires improvement because although there were many good things about the service, it breached a regulation relating to the fit and proper persons test for board level managers. This means we cannot give a rating higher than requires improvement. We found:

- The management team were not clear about their roles and their accountability for ensuring directors met the 'fit and proper person' regulation.
- There were some concerns about the consistency and understanding that the management team had concerning the 'duty of candour' requirement.

However:

- The unit had a strong focus on continuous learning and improvement and staff innovation was supported.
- The service was transparent, collaborative and open with relevant stakeholders about performance. Leaders at every level prioritised high quality compassionate care.
- Leaders modelled and encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. Staff said managers were available, visible, and approachable.

Vision and strategy for this this core service

- The vision of Epsomedical Limited was for the unit to provide patients with consultant-led care in a suitable environment with high standards of care.
- The unit staff told us they defined their clinical services as being joint ventures between the clinician and the unit, recognising that both must work as a team with commonality of objectives. In addition, they aimed to provide clinicians with all the support required to plan and deliver services effectively. Staff told us that their interpretation of the unit's vision was to offer the best care to patients and offer a better service than other providers within the area.
- There was a strategy to develop the service. The management team told us that the priorities for the following year included building up the core services, development of an interactive website where patients had access to their records, consolidation of the management team to create strength in more depth and improve relationships with local NHS bodies and

finding opportunities for collaboration. The unit aimed to offer commissioners the best value for money, with fully transparent reporting of patient pathways and activity, and prices below tariff.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure in place. The management group met monthly and discussed clinical governance, incidents, complaints and the risk register. We saw the meetings agreed organisational aims and communicate these objectives to staff through the medical advisory committee (MAC) and departmental meetings.
- Consultants from a variety of surgical specialities attended the MAC meetings on a quarterly basis. Records demonstrated a variety of topics were discussed for example, incidents, complaints and practicing privileges. Clinical quality and governance issues were reviewed at the six monthly MAC meetings. The MAC was responsible for ensuring there were robust systems and processes in place in relation to governance and assurance.
- The information discussed at the board and MAC meetings were cascaded to the wider team through separate departmental and clinical meetings. For example we saw in the July 2016 clinical staff meeting minutes that all theatre staff were asked to familiarise themselves with The National Safety Standards for Invasive Procedures.
- We saw a comprehensive clinical audit schedule to provide quality assurance. Audits related to surgery included infection prevention and control, hand hygiene, venous thromboembolism (VTE) screening, theatres, and the WHO checklist for safer surgery.
- The unit utilised the daily 'team briefings' and 'debriefings' as an effective way to share information and drive continuous improvement. We saw that the 'briefings' were documented and kept in theatres and staff were encouraged to read them to ensure learning was shared. We reviewed a sample of the 'debriefing' documents and they included details of what had gone well and what could have been improved. This demonstrated staff wanted to acknowledge what had gone well during the operating list and where improvements could be made.
- Assurance of good quality outcomes was achieved in various ways. For example from patients through their feedback, from external organisation such as the CCG and from local GP's.
- We reviewed the Epsomedical Risk Management Policy, this policy set out what risks must be assessed and how they must be assessed. For example using a standard risk assessment matrix template as a tool for assessing different risks associated with patient safety and data protection. This method would be used when assessing risks such as: Information governance, business continuity including network security, health and safety and theatres. This demonstrated that the provider had systems to ensure risks were assessed and measures put in place to mitigate the risks. We saw examples of these assessments for example safe storage of patient information. It included what measures there were in place to manage the risks related to loss of patient information or a breach of security related to patient information.

Leadership / culture of service related to this core service

- 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. Operational staff understood their responsibilities with regard to the duty of candour legislation and we found the responsible manager ensured that the duty was considered and met when investigating safety incidents. However, we were not assured that the executive team where familiar the duty or their responsibility to ensure the requirement was adhered to, although the responsible manager ensured that the duty was considered and met when investigating safety incidents. This meant that patients might not be informed or receive an apology if a notifiable safety occurred. In addition patients would not receive the support they required should a safety incident, which affected them, occur.
- Any independent unit that undertakes work for the NHS that generates an income of over £200,000 in any twelve month period is obliged to collect and publish data according to the Workforce Race Equality Standards (WRES). This includes, but is not limited to, the ethnicity

of its staff and the positions held by those staff. The requirement for independent health (IH) providers is that this data must be published by July 2017. However, all IH providers need to demonstrate how they are working to collect the data. The management board of Epsomedical Limited were unaware of their obligations with regards to WRES and had not yet given consideration as to how they might meet this requirement.

- Epsomedical Limited has an obligation to ensure the management team fulfils the 'fit and proper person' regulation. The 'fit and proper person' regulation requires the provider to ensure the management team are of good character, have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed. During discussions with two board members we were not assured that there was a robust process in place to ensure compliance with this regulation. Although some checks were carried out on new board members, these did not meet all the requirements of the regulation, for example checking that the candidate was not bankrupt. There were no arrangements to ensure checks were carried out to ensure board members remained fit and proper person. This meant there was not a process to ensure the management team were compliant with the 'fit and proper person' requirement.
- We saw leaders valued and respected staff. Staff generally felt valued and told us that leaders were visible and approachable. All staff told us the senior management team were highly visible throughout the unit, often undertaking walk arounds to all areas. Staff told us they felt supported by their managers and colleagues.
- We saw that staff worked well together and respected each other and worked as a team.
- There was a culture of transparency and honesty amongst staff. Staff told us managers encouraged and supported them to report incidents.
- Staff told us they enjoyed their jobs, were proud of the unit and of the treatment and care they provided to patients.
- Consultants we spoke with were positive about senior members of the unit and described good working relationships.

Public and staff engagement

- Staff were encouraged to complete annual staff surveys. We reviewed the 2016/7 survey which demonstrated 57% of staff said they were either extremely likely or likely to recommend Epsomedical Limited as a place to work. In addition, 76% of staff said they were extremely likely or likely to agree with the statement that patients were Epsomedical Limited top priority.
- There were clear lines of responsibility and accountability within the team, which were easily identified by staff.
- There were forums for staff to communicate with the management team, which included departmental meetings, bulletin boards on the bespoke computer software system.
- The management team worked closely together and met daily. There was monthly board meetings to formally agree the organisational aims and we saw these were communicated to staff through the MAC, Endoscopy User Group and departmental meetings.
- The provider produced monthly newsletters and regular clinician bulletins to engage with staff and communicate developments within the organisation.
- The unit monitored patient satisfaction, this was achieved through obtaining patient feedback and views through the Friends and Family Test (FFT) and patient satisfaction surveys which could be completed on paper or on the website.
- There was a close relationship with Clinical Commissioning Group's (CCG's) and the organisation produced a GP bulletin, to ensure the two way exchange of information.
- We saw noticeboards displaying information around the unit to inform staff on a variety of subjects for example infection prevention and control, health and safety, safeguarding and lessons learned from incidents and complaints.

Innovation, improvement and sustainability

Requires improvement

Surgery

- Epsomedical Limited have developed a bespoke innovative computer software system, which tracks patients at every stage of their journey. This meant it was easy to identify at what stage a patient was at in their journey quickly and easily. The system contained all patient information, which reduced the risk of delays due to lost patient records. In addition, the system was used as a planning tool giving the facility to plan eight weeks ahead, which ensured efficiency, by careful planning and organisation. Epsomedical Limited wanted to develop the system further creating an interactive website where patients have access and are able to manage their own appointments and review waiting time for convenience.

Good

Outpatients and diagnostic imaging

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

Information about the service

Epsomedical Group is the provider for the outpatients departments at both Cobham and Epsom Day Surgery units. The units are run jointly and the staff cover both sites. Therefore some of the data in the report is not site specific.

Cobham Day Surgery is an independent provider of outpatient and some diagnostic imaging services. The facilities are focussed on elective care with defined operational hours. The department is open 8am to 6pm Monday to Friday. The unit has occasional clinics on a Saturday to accommodate the needs of the service.

The vast majority of patients are NHS funded. Epsomedical Limited carries out minimal private work which represents less than 1% of their activity. There were 18,456 outpatient attendances in the reporting period April 2015 to March 2016 at Cobham Day Surgery. Of these, 99.6% were NHS funded.

Referrals are accepted for the outpatient and diagnostic imaging departments for adults above the age of 18 only. The service had previously seen children from the age of three but no longer accepts these referrals.

The outpatient department has seven consulting rooms and one treatment room. The outpatient service provides several specialities including, but not limited to: dermatology (disorders of the skin, nails, hair and their diseases), ophthalmology (diseases and conditions of the eye), orthopaedics (conditions affecting the muscles, bones and joints), ear, nose and throat (ENT) and gastroenterology (disorders of the stomach and intestines).

The diagnostic imaging department consists of one examination room and a separate changing room. The service operates part time Monday to Friday depending on the level of demand. Services provided include x-ray (an effective way at looking at the bones) and ultrasound (uses high-frequency sound waves to create an image of part of the inside of the body). Other diagnostic testing, for example MRI and CT are outsourced services to other providers and were not provided on site. Therefore these services were not part of this inspection.

We spoke with and observed the care provided by 17 members of staff including nurses, radiographers, health care assistants, administrators and managers. We spoke with four patients and one of their relatives. We looked at six sets of patient notes. We made observations of the environment and equipment staff used.

As part of our inspection, we looked at hospital policies and procedures, staff training records and audits. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the unit.

Good

Outpatients and diagnostic imaging

Summary of findings

We found the outpatient and diagnostic imaging services at Cobham Day Surgery to be good. This was because:

- The unit had systems and processes in place to keep patients free from avoidable harm.
- Infection prevention and control practices were in line with national guidelines. Areas we visited were visibly clean, tidy and fit for purpose. The environment was light, airy and comfortable. A wide range of equipment was available for staff to deliver a range of services and examinations.
- Medicines were stored in locked cupboards and administration was in line with relevant legislation.
- Staff kept medical records accurately and securely in line with the Data Protection Act 1998.
- The unit had a comprehensive audit programme to monitor services and identify areas for improvement.
- The outpatient and diagnostic imaging services had sufficient numbers of appropriately trained and competent staff to provide their services. Staff completed appraisals regularly and managers encouraged them to develop their skills further.
- Staff interacted with patients in a kind, caring and considerate manner and respected their dignity. Patients told us they felt relaxed when having their treatment.
- The unit was responsive to the needs of the local populations. Appointments could be accessed in a timely manner and at a variety of times throughout the day.
- Managers were visible, approachable and effective. The hospital had a management board and medical advisory committee (MAC) both were responsible for ensuring there were robust systems and processes in relation to governance and assurance.

However:

- The unit did not monitor and record the cleaning of consultation rooms on a regular basis.

Are outpatients and diagnostic imaging services safe?

Good

We rated safety in this service as good. This was because:

- Incidents were reported by staff. There was evidence of learning achieved and the resulting changes in practice that took place. Staff informed us they were encouraged to report incidents to enable learning as an organisation.
- Patients were cared for in a visibly clean environment which was well maintained. There were arrangements to prevent the spread of infection and compliance with these was monitored.
- There were adequate supplies of appropriate equipment that was properly maintained to deliver care and treatment and staff were competent in its use.
- Staff demonstrated good medicines storage and management. There were systems to ensure patient's medicines were given safely and were stored securely as per national guidelines.
- We found patient's records were legible, complete and accurate. There were systems to ensure records were stored securely.
- The hospital had sufficient numbers of appropriately trained staff to provide safe care to patients. The majority of staff had completed the provider's mandatory training programme. Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances.

However:

- The hospital did not monitor and record the cleaning of consultation rooms on a regular basis.

Incidents

- The unit reported no never events from April 2015 to March 2016. Never Events are serious incidents that are wholly preventable as guidance or safety

recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- The unit reported no serious incidents or deaths reported in the period April 2015 to March 2016 as none had occurred.
- The unit reported no ionising radiation (medical exposure) regulations IRMER incidents to CQC in the last 12 months. Staff had a clear understanding of what was a reportable incident. A Radiation Protection Advisor (RPA) was available for advice, by telephone, if required.
- The unit had an incident report writing policy dated 2016 and staff used an electronic incident reporting system. Staff had a good understanding of how to use the system. Staff told us feedback from incidents was discussed at departmental meetings. We saw minutes of meetings which confirmed this. Staff told us the unit encouraged them to report incidents to help the whole organisation learn from them. Staff were able to give us examples of incidents that had been reported in the past.
- The rate of incidents reported was lower than the other independent acute hospitals the Care Quality Commission (CQC) holds data for. There was one clinical incident reported in the outpatient department. This incident occurred between January and March 2016 and related to a member of the public reporting to the reception desk and complaining of chest pain. The staff responded appropriately and arranged for the member of public to be transferred to the local NHS acute trust.
- There were no non-clinical incidents reported in the period April 2015 to March 2016.
- We saw reported incidents were graded according to severity and investigated by the management team to establish the cause. These were then reported locally to departmental teams, the management board, the medical advisory committee (MAC), the local clinical commissioning group and other relevant organisations as required.
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This 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. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The unit apologised and informed people of the actions they had taken and records confirmed this.
- Staff said the dissemination of information was through electronic communications and their attendance at staff meetings. We also reviewed a sample of hospital wide clinical incidents, patient's notes and root cause analysis and saw evidence that staff had applied the duty of candour appropriately.

Cleanliness, infection control and hygiene

- There were no incidences of E-Coli, meticillin-resistant staphylococcus aureus (MRSA) and meticillin sensitive staphylococcus aureus (MSSA) bloodstream infections or cases of clostridium .difficile related diarrhoea reported in the period April 2015 to March 2016 at the hospital. These are all serious infections with the potential to cause harm to patients.
- Epsomedical Limited had a policy for decontamination of medical devices dated 2016. Decontamination is the combination of processes including cleaning disinfection and sterilisation, which is used to make a reusable device safe for further use on patients and for handling by staff.
- Epsomedical Limited had a current infection control policy dated 2015. This was to facilitate effective infection control in each unit including policies, procedures, training and effective management.
- Infection control services for Epsomedical Limited were outlined in a service level agreement between the provider and a local acute NHS trust which we saw. We were told infection control was the responsibility of registered managers, department link nurses and all staff.
- The infection control committee met annually and we saw the report produced. Areas covered included systems to manage and monitor infection prevention and control, provide and maintain an appropriate environment and provide suitable accurate information for service users.

Good

Outpatients and diagnostic imaging

- All the areas we visited in the outpatients and diagnostic imaging departments were visibly clean and tidy and we saw there were good infection control practices in place.
- Staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines on hand hygiene in health care.
- There were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. Information was displayed demonstrating the 'five moments for hand hygiene' near handwashing sinks. Sanitising hand gel was readily available throughout the unit.
- We saw personal protective equipment was available for all staff and staff used it in an appropriate manner.
- The cleaning of the unit was outsourced to a private cleaning company. The reception area of the unit had a communication book where staff and cleaners could leave messages for each other. We noted this was checked on a daily basis when the unit was open and where actions had been taken, this was recorded.
- We saw the cleaning schedule for the diagnostic imaging department and this was completed on a daily basis when the department was open.
- The flooring was seamless and smooth, slip resistant, easily cleaned and appropriately wear-resistant. This was in line with HBN 00-09: Infection control in the built environment, 3.109.
- We saw the majority of the seating in the outpatients department was covered with a wipe able fabric. HBN 00-09 section 3.133 for furnishings states all seating should be covered in a material that is impermeable, easy to clean and compatible with detergents and disinfectants. We saw there was on ongoing programme of replacement for the fabric chairs, when damaged, with a suitable material in line with the HBN recommendation.
- Waste in the clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with the Department of Health (DH) Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.
- We saw water was tested and reported to the water committee as required by the water safety management regime HTM 04-01. The required full annual check and appropriate monthly tests were completed.
- We saw sharps bins were available in treatment and clinical areas where sharps may be used. This demonstrated compliance with health and safety sharps regulations 2013, 5(1)d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the labels on sharps bins had been fully completed which ensured traceability of each container.
- Epsomedical Group audited the sharps bins in June 2016. Overall there was good compliance however there was some areas in need of improvement. We saw Cobham Day Surgery was 100% compliant in all areas except for three minor points. All staff were sent the results of the audit. The analysis was discussed at the department meetings and the audit was to be repeated in September 2016.
- An infection control audit and report was produced annually for each site. The result of the 2014/15 Cobham Day Surgery infection control audit, undertaken in September 2014, found the unit was compliant with a score of 92%, which was better than the target of 85%. The audit was reviewed in January 2015. The audit considered the environment, patient equipment and sharps handling and disposal. Where any audit element did not meet the required standard, recommended actions and timescales were provided to achieve improvements. For example, it was found in consulting room three in the outpatients department the disposable curtains were dated February 2014 and beyond the routine replacement date. During the inspection we saw disposable curtains used in the treatment and consultation rooms. The dates on them indicated they had been changed within six months.
- The audit was repeated in June 2016. The overall score was 94%. Non-compliance related to soap dispensers in two rooms which were visibly soiled around the

dispensing nozzles, the sharps tray in the treatment room was visibly soiled and the storage trolley was found to be dusty. At the time of inspection we found all of these areas to be satisfactory.

- The hospital audited the cleaning areas on a monthly basis with the cleaning subcontractor. We saw the evidence of these audits and the actions planned. The audit in June 2016 scored 97.6% this was slightly worse than the target of 98%. The area highlighted concerned the dusting of high levels areas not being fully completed and an action plan was generated. The audit in August 2016 achieved 98%. There was no action plan as there were no deficiencies.
- The consulting rooms in the outpatients department had cleaning schedules pinned to the notice boards. This was for a weekly check. The cleaning schedule was for the couches including wheels, and to ensure sufficient stock was in each room. However the schedule in two out of eight rooms was incomplete. In room four the schedule was last completed 29 August 2016 and room six, 22 August 2016. This meant there was no assurance the areas had been cleaned.

Environment and equipment

- The consultation rooms were equipped with a treatment couch and trolley for carrying the clinical equipment required. The room had equipment in it to provide physical measurements (blood pressure, weight and height). This was in line with HBN 12 (4.18) which recommends a space for physical measures be provided so this can be done in privacy.
- We saw equipment service records which indicated 100% of electrical equipment had been serviced in the last 12 months. Individual pieces of equipment had stickers to indicate equipment was serviced regularly and ready for use. We saw electrical safety testing stickers on equipment, which indicated the equipment was safe to use.
- Six out of the seven consulting rooms had patient couches. The electrical testing of these were recorded as due January 2016. This meant regular checks had not been done to ensure the couches were safe to use. We highlighted this to the facilities manager who was not aware the service was due and investigated further. We were told the unit relied upon the contractor contacting the hospital when the service was due and the hospital did not keep a record of this. The hospital recognised this was an issue and were in the process of completing an asset register which would highlight when services were due or a contract had expired. The register was not completed, however we saw the evidence that the process was in place. At the time of leaving the hospital an arrangement had been made to ensure the couches would be serviced.
- We saw certificates to indicate staff were competent to use equipment. Staff reported no problems with equipment and felt they had enough equipment to run the service.
- We saw records of the three monthly quality assurance tests of diagnostic imaging equipment. In addition to this a radiation protection committee reported annually on the quality of radiology equipment, which we saw. These mandatory checks were based in the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R2000). The quality assurance tests on the dual-energy x-ray absorptiometry (dexa) machine were completed before every use as prompted by the machine.
- Lead aprons were available in the diagnostic imaging department. We saw evidence which showed checks of the effectiveness of their protection occurred regularly and equipment provided adequate protection.
- The ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R2000) state medical facilities operating x-ray machines are required to post 'in use' warning signs outside room doors. The diagnostic imaging department had a warning sign in place to ensure patients and staff were safe. However, when we inspected the light was not working correctly. The light showed when exposure was being made but the x-ray warning light was not illuminated. This was highlighted to staff and we saw this was corrected immediately.
- We saw confidential waste was managed in accordance with national regulations. Confidential waste areas were available in administration areas and we saw the certificates of destruction supplied by the outsourced shredded waste company.
- Emergency equipment was located in the treatment room of the outpatients department. The resuscitation trolley, with defibrillator, was in a secure position. The

senior nurse checked the top of the trolley daily and all the equipment monthly. The defibrillator battery was changed every month and tested. We saw the records of checks. All equipment needed was available, as indicated by an equipment list. All consumables were in date. The seals of the trolley were checked daily when the department was open and we saw the records of this. The records stated clearly 'not in use' on the days the unit was not open.

- Fire extinguishers were serviced appropriately and in prominent positions. Fire exits were clearly sign posted and exits were accessible and clear from obstructions.

Medicines

- Epsomedical Limited had a drugs and medicines policy dated 2013, due for review August 2016. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of drugs.
- Cobham Day Surgery did not have a pharmacy service on site. The pharmacy service was provided by the local NHS hospital who visited when required. All medicines were ordered via the local NHS hospital pharmacy.
- No controlled drugs (CD's) were kept or administered in the outpatient department.
- Consultants administered medicines in the outpatients department and these were accessed by the nurses and health care assistants who held medicine cupboard keys. Medications were kept in a lockable cupboard which was secured to the wall. Only authorised staff had access to these keys.
- Medications, for example eye drops, were checked weekly for expiry dates and stock levels. We saw the completed forms which were forwarded to the clinical director.
- Staff monitored and recorded the minimum and maximum temperatures of the locked medicine refrigerator, where relevant eye drops were stored. Room temperatures were also checked and recorded. We saw the records which indicated this was done daily when the department was open and clearly recorded when the department was closed.
- Epsomedical Limited had a safe and secure management of prescription forms policy dated 2016. This was to ensure all blank prescriptions were recorded and securely stored within a locked cabinet within a lockable room or area.
- All prescriptions were generated electronically. We saw the prescriptions were locked in the printers. The hospital had a supply of prescriptions which could be hand written in the event of a technical fault. These were secured in a locked cupboard and records were made when issued. The handwritten prescription would be copied and scanned on to the electronic system and then destroyed.

Records

- The unit used a variety of information technology systems that held patient data. All staff, clinical and non-clinical were required to be compliant with information security and data protection with all services around patients. We saw staff completed mandatory e-learning modules for information governance. Between April 2015 and February 2016, 92% of staff had completed training for information security and data protection. Some staff, for example doctors, were provided with an NHS email address for confidential transfer of patient data.
- The provider told us that in the three months before the inspection no patients were seen in outpatients without all relevant medical records being available.
- All patient records were stored on a patient administration system (PAS). There were four levels of access to PAS and only those authorised had access to the appropriate level. Any paper generated documents were scanned on to this system and then shredded.
- We looked at six sets of patients records. We saw records were complete, legible and signed appropriately. They contained letters, results of diagnostic tests, discharge letters and the record of consultations and nursing treatment.
- Epsomedical Limited audited their records between April and June 2016. This examined the compliance regarding the generation of outcome letters following outpatient consultation. The outpatient department across both Cobham and Epsom Day Surgeries scored 99.9% for compliance. Total attendances for the period

were 5,864 and of these two were missing outcome letters. The explanation for the two missing letters were justified with the consultant who felt one outcome letter was not applicable and the other the letter was generated but attached to the incorrect activity. Once noted this was sent to the GP following the consultation.

- The provider recognised the circumstances in which a patients record may not be available were due to either administrative or system errors. Administrative errors could be due to documents not being uploaded by the team or to the relevant PAS file. System errors may be electrical or connection. The administration staff talked us through the process in the event of errors. To remedy the risk of these errors the administrative team created a patient record, if not already in existence, on receipt of a referral. The referral would be immediately uploaded and then triaged to the appropriate speciality. Any missing documentation could be accessed and uploaded by the scheduling support team.
- System errors would result in an inability to view the records. There was a network system in place which informed IT department and the service provider of any outage in connection to the PAS. Immediate investigation and action plan would take place. Complete loss of access to the server would be covered by the disaster recovery plan to minimise data loss. The system ensured there was a continuous synchronisation between the live PAS and the backup server.
- The provider could ensure that medical records were never taken off site as all the records were held electronically. The PAS system ensured all records were available at all stages of the patient's pathway as they were held centrally.

Safeguarding

- The location lead for safeguarding adults was the compliance manager and a registered nurse. The location lead for safeguarding children was the compliance manager and the medical director. Both were trained to level 3 safeguarding children in line with national guidance.
- Epsomedical Limited had a child protection (safeguarding children) policy dated 2016, to ensure that appropriate action was taken to protect children from any form of abuse. All staff undertook safeguarding awareness training. The policy contained contact information for staff in the event of suspected abuse.
- Safeguarding training was part of mandatory training. Eighteen members of staff were trained to level 2 safeguarding children. Training records showed 100% of clinical staff had completed safeguarding adults training and 96% had completed safeguarding children. Administrative staff had completed safeguarding children training (89%) and safeguarding adults (81%).
- Staff had a good understanding of what a safeguarding concern might be. They told us they would escalate any concerns to their manager. They knew who the safeguarding lead was. We saw there was safeguarding flow charts displayed in clinical areas to provide advice and prompt staff.

Mandatory training

- Staff were required to undertake a mandatory training course as soon as they started employment with the Epsomedical Limited. The content of the course was designed to cover the areas where the provider was subject to regulation from other bodies and was under a duty to ensure that all staff complied. The courses included health and safety, information management, equality and diversity, vulnerable adults and children at risk.
- All mandatory training was completed in one day on a face to face basis external to the hospital.
- We saw the training records for staff (excluding medical staff) for mandatory training. These showed clinical staff mandatory training included information governance (100% attendance), infection control (100%) and manual handling (100%). Administrative staff mandatory training included information governance (93%), working with display screens (93%) and manual handling (89%). Epsomedical Limited target for mandatory training for all staff was 85% and this target was exceeded in all topics.
- Staff told us they were given protected time to complete mandatory courses. They were also given the option to access the courses from their home computers and awarded time off in lieu for hours worked.

Assessing and responding to patient risk

Good

Outpatients and diagnostic imaging

- We saw there was adequate resuscitation equipment and it was easily accessible. Staff knew where it was located. We saw it was checked daily to ensure it was ready for use.
- All nursing staff and health care assistants (HCA's) in the outpatient and diagnostic imaging departments received basic life support training. No members of staff had advanced paediatric life support training as children and young people were referred elsewhere for interventional treatment.
- Signs were displayed throughout the department with the nominated first aiders and fire wardens.
- Transfer arrangements to associated hospital trusts were outlined in the Epsomedical Limited transfer policy. This defined the responsibilities of visiting clinicians and permanent staff. The need for these arrangements would be identified during the patient's admission to the unit and an assessment of the type of continuing care made.
- On routine discharge from the unit, patients were given concise written instructions on whom to contact if they require support or information during opening hours and when the hospital was closed. Clinical nurse specialists in dermatology and ophthalmology were available for advice and support.
- A radiation protection supervisor was on site for each diagnostic test and a radiation protection advisor was contactable if required. This was in line with ionising regulations 1999 and regulations (IR (ME) R 2000).
- The diagnostic imaging department had a stop button on the wall to stop the radiation examination in an emergency. We saw the records demonstrating this was tested weekly.

Staffing

- Epsomedical Limited used an electronic rostering system for calculating staffing requirements to support the outpatient and diagnostic imaging departments.
- The department manager formulated an eight week roster which identified the staffing needs according to planned activity. This roster was transferred to the main system and reports were generated for managers to identify any conflicts that could occur and the effective utilisation of staff across both Cobham and Epsom Day Surgeries. It also highlighted any gaps caused by absences of staff, for example sickness, annual leave or training commitments. The staff were able to view their allocated duties online.
- The hospital told us they had 70 consultants working with agreed practice privileges at the unit. This related to consultants in post at 1 April 2016 with more than 12 months service.
- We saw the Epsomedical Limited practising privileges policy. We saw all medical staff had been fully trained to perform a procedure which they regularly performed within their NHS practice. The medical director was responsible for the granting and revoking of practising privileges.
- The granting of practicing privileges is a well-established process within independent unit healthcare sector whereby a medical practitioner is granted permission to work in a private unit or clinic in independent private practice, or within the provision of community services. There should be evidence that the provider has fulfilled its legal duty to ensure compliance with regulationc19 in respect of staffing. Where practicing privileges are being granted, there should be evidence of a formal agreement in place. We saw that these agreements were in place for all medical staff with practicing privileges.
- The unit employed four whole time equivalent (WTE) registered nurses and two WTE health care assistants (HCA) in the outpatient and diagnostic imaging department.
- As of April 2016 there was one HCA WTE post vacancy. There were no vacancies for nurses. We saw the gaps in the rota were filled with bank and agency staff. The provider told us the percentage of agency staff across both hospitals in all departments was 1% of all clinical hours between January and July 2016. The use of bank staff was 19% of all clinical hours.
- There was adequate radiographer cover to run the service. Two radiographers worked at Cobham Day Surgery and both worked part time. One radiographer was on site at a time. The unit had an arrangement with a bank radiographer to cover annual leave and sickness.

Major incident awareness and training

- Epsomedical Limited had a disaster handling and business continuity plan dated 2016. The plan was

designed to enable the hospital to overcome any unexpected disaster to its premises, key personnel or to any important systems relied upon in day to day operations. The plan contained information of contacts and checklists for specific situations. Staff told us they were aware of the plan and showed us they could access this on the computer.

- Fire training was part of mandatory training for all staff. Clinical staff had achieved 100% and 89% of administrative staff, better than the target of 85%.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effectiveness as we do not currently collect sufficient evidence to rate this.

- We found care and treatment reflected current national guidance. There were systems in place for collecting and monitoring comparative data regarding patient outcomes.
- The unit had an on-going, comprehensive audit programme which monitored areas for improvement regularly.
- Staff worked with other healthcare professionals internally and externally to the unit to provide services for patients. Patients were cared for by staff who had undergone specialist training for the role and who had their competency reviewed.
- Patients provided informed, written consent before commencing their treatment. Where patients lacked capacity to make decisions, staff were able to explain what steps to take to ensure relevant legal requirements were met.

Evidence-based care and treatment

- The unit had a robust audit programme throughout all clinical departments. Regular audits included patient health records, medicine management, hand hygiene and infection prevention and control. We saw copies of these audits which overall showed compliance with the unit's policies and targets. Findings were reported to the departments and through to the management board meetings. Trends were identified and action plans created to improve the service to patients which was communicated back to the clinical departments for their action.
- We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. For example, National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Radiologists.
- The imaging department had policies and procedures in place. They were in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000) and in accordance with the Royal College of Radiologist's standards.
- The Radiation Protection Advisor (RPA) undertook regular radiation audits and an annual review of dose reference levels. We saw the minutes of the meetings for the last three years and results of audits.
- In the outpatient and diagnostic imaging departments, staff demonstrated how they could access NICE guidelines and relevant policies on the hospital's computer system. We saw local rules available in the diagnostic imaging room. Staff had signed them to indicate they had read them.

Pain relief

- In the outpatient department doctors could prescribe pain relieving medicines if required.
- In the diagnostic imaging department, there were a variety of pads and supports available to enable patients, having examinations, to be in a pain-free position.
- The podiatry consultant carried out an audit across both Cobham and Epsom Day Surgeries, which included an assessment of pain relief. The audit was started in October 2015 and used a recognised tool. The aim of the audit was to determine the levels of pain for 43 patients before and after podiatry treatment. We saw the audit showed a consistent improvement in pain levels following treatment. Before treatment patients scored 31 for pain levels and after treatment 15.

Patient outcomes

- We saw the hospital audited patient outcomes by participating in national and local audit programmes. National and local targets were set by the main Clinical Commissioning Group (CCG) who set a clear framework

of expectations and progress. We saw the monthly activity returns submitted and noted targets were being achieved. Epsomedical Limited benchmarked itself against comparative data from local trusts.

- Performance was also monitored by submitting data to the Secondary Uses Service (SUS) which is the comprehensive source for healthcare data in England. This enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.
- Data submitted measured performance against key indicators. The hospital had regular review meetings where results were discussed with reference to how they could develop practices to improve upon services delivered. The hospital audited patient outcomes by providing clinical governance reports to the management board, medical advisory committee (MAC) and other specialist groups.

Competent staff

- All staff had an induction programme devised by their departmental manager. This included a tour of the facilities and teams, supervised work sessions and protected time for reading the relevant policies and protocols. The induction course was written using a standard template, signed off on completion by the responsible manager and filed in the employee's personnel record. Staff showed us these records.
- We saw staff competency documents for staff including nurses, and radiographers, all of whom had the relevant qualifications and memberships appropriate to their position. There were systems which alerted managers when the professional registrations of staff were due so they could check these were renewed. We saw examples of these.
- We saw documents for a variety of activities that assured competence such as mandatory training and completed induction packs. Clinical staff were required to complete a series of clinical competencies relevant to their role. The compliance manager was responsible for signing off the acquired competencies for all personnel. We saw the individual records for staff which showed their completed competency assessments.
- Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the Nursing and Midwifery Council (NMC).
- In compliance with IR (ME) R regulations, we saw certificates were held for staff who were able to refer patients for diagnostic imaging tests. This gave assurance that only those qualified to request a diagnostic examination were able to do so.
- All the staff we spoke with had received an annual appraisal. During the annual review individual responsibilities were outlined. They told us this process was effective in developing their skills and knowledge further. It also contributed to maintaining registration with their regulatory bodies. We saw that staff were supported through revalidation processes.
- The Epsomedical Limited encouraged staff to enhance their qualifications where this matched operational requirements. For example, a member of the clinical staff in the outpatients department told us they had highlighted the need to attend a phlebotomy course to extend their skills during their recent appraisal. We were told this request had been received positively and a place had been booked on the course.
- In 2015, 100% of staff in the outpatient and diagnostic imaging department had received an appraisal. In the current year (January 2016 to December 2016) no staff had received an appraisal. At the time of the inspection staff appraisals for the year 2016 had not occurred. However the hospital was in the process of completing these.
- We saw the results of the Epsomedical Limited staff survey 2016/17. The percentage of staff who felt their appraisal helped to improve their job was 39% and 33% of staff said it did not.
- We saw the hospital received assurances from the sole agency used for nursing staff. This included training, qualifications, disclosure and barring service (DBS) check, immigration status, professional registration and details of induction.
- The MAC was responsible for granting and reviewing practising privileges for medical staff. The hospital undertook robust procedures which ensured consultants who worked under practising privileges had the necessary skills and competencies. The consultants received supervision and appraisals. Senior managers ensured the relevant checks against professional registers and information from the DBS were completed. The status of medical staff consultants practicing privileges was recorded in the minutes of the MAC notes.

Multidisciplinary working (related to this core service)

Good

Outpatients and diagnostic imaging

- Staff told us they worked well together and had good communication with other health care professionals and administrative staff. We saw staff engage in a professional and courteous manner.
- The RPA service for the diagnostic imaging department was provided by the local NHS acute trust. The hospital had annual radiation protection meetings at the hospital.

Seven-day services

- The department was open 8am to 6pm Monday to Friday. The unit has occasional clinics on a Saturday to accommodate the needs of the service.

Access to information

- We saw in the diagnostic imaging department staff were provided with the protocols of examinations undertaken. A folder was kept in the department to guide radiographers explaining how to perform a procedure, the reason for the procedure and to what level the exposure to be set.
- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system (PACS). This is medical imaging technology which provides economical storage and convenient access to diagnostic images from multiple machine types. Other areas of the hospital were able to access the PACS system.
- Staff from both departments could access a shared drive on the computer where policies and hospital wide information was stored. Staff demonstrated this to us.
- Diagnostic imaging test reports were sent to a private medical imaging company electronically for analysis. We were told the reports were returned to the hospital within 24 hours via a secure source with a numerical identification. The reports were attached to the patient's records electronically and emailed directly to the GP. We saw evidence of this in patients' records.
- The provider reported that no patients were seen without relevant medical records being available in the previous three month and we saw that clinicians had access to relevant records when the saw patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Epsomedical Group had a consent to treatment policy dated 2013. The policy demonstrated the process for consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits. The policy also incorporated the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). The policy had clear guidance that included the Mental Capacity Act (MCA) 2005 legislation and set out procedures that staff should follow if a person lacked capacity.
- We spoke with a range of clinical staff who could all clearly describe their responsibilities in ensuring patients consented when they had capacity to do so or that decisions were to be taken in their best interests.
- We saw signed consent forms in medical records. This meant patient's had consented to treatment as per the hospital policy. We saw the forms outlined the expected benefits and risks of treatment so patients could make an informed decision.
- Epsomedical Group had a policy for clinical photography of patients 2014 to ensure all staff kept records confidential and secure and were aware records were protected under the Data Protection Act 1998. We saw the forms used for this consent.
- We saw patients for the diagnostic imaging department had their identity confirmed by asking name, address and date of birth. This followed IRMER requirements. We saw the request forms and signatures of staff to identify that identities had been checked.

Are outpatients and diagnostic imaging services caring?

Good

We rated the services as good. This was because:

- Staff provided sensitive, caring and individualised personal care to patients. Staff supported patients to cope emotionally with their care and treatment as needed.
- Patients commented positively about the care provided from all staff they interacted with. Staff treated patients courteously and with respect.
- Patients felt well informed and involved in their procedures and care.
- Signs offering chaperones were clearly displayed, the services held chaperone registers and staff were suitably trained to chaperone.

Good

Outpatients and diagnostic imaging

- Patient's surveys and assessments reflected a friendly, kind and caring patient centred ethos.

Compassionate care

- We saw staff treating patients in a kind and considerate manner. Patients and their relatives told us staff always treated them with dignity and respect. We saw staff introduce themselves to patients and explain their role.
- We saw signs in the patient waiting areas informing patients they could have a chaperone, if required. We saw certificates which indicated staff had chaperone training. Staff would record if a chaperone had been offered and document if a patient agreed or declined. In a separate register it was recorded who had been a chaperone, the patient concerned and the day it occurred. We saw the chaperone register which indicated this was occurring. This was in line with the hospital's chaperone policy.
- We saw there was an individual changing cubicle attached to the diagnostic imaging department which ensured patient's privacy and dignity were maintained.
- Data was submitted to the Friends and Family Test (FFT) for NHS patients only. The patient satisfaction survey results for 2014/15 for Epsomedical Limited (this related to both Cobham and Epsom Day Surgery Units) was 99.6% of patients would recommend services to their friends and family. The unit's FTT score was 99.3% for their 2015/16 survey.
- The provider received two items of rated feedback on the NHS Choices website in the reporting period April 2015 to March 2016. Both were "extremely likely to recommend" the hospital.
- The outpatients department had five thank you cards from patients to staff displayed. Comments included "thank you for guiding me through the procedure, start to finish I received kind, helpful and informative information", "excellent treatment and after care" and "thank you for doing all you have done to restore my eyesight and rid me of cataracts".
- During the inspection we asked patients to complete feedback forms to describe their experience of the outpatients and diagnostic imaging departments at the hospital. We collected six completed cards which were all positive about the hospital and service received. Comments included "I have been treated with politeness and a caring attitude", "the service here has been excellent", and "I have been pleased with the care I have received, both for procedures and after care".

Understanding and involvement of patients and those close to them

- Staff discussed treatments with patients in a kind and considerate manner.
- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need.
- Staff sent detailed information about the examination patients were booked in for with the appointment letter. We saw examples of this information and it was in a clear and simple style and language.

Emotional support

- Staff could access counselling services and other psychological support for a patient if it was needed.
- We saw staff interacting with patients in a supportive manner and provide sympathy and reassurance.
- Nurses would attend clinic appointments with patients to provide emotional support if required. Staff told us they were able to provide patients and their families extra time if necessary.
- Staff told us if they were present when bad news had been given to a patient, their line managers and other members of the team provided support.

Are outpatients and diagnostic imaging services responsive?

Good

We rated the services good for responsive. This was because:

- Services operated at times that allowed patients to access care and treatment when they needed it.
- There were a variety of mechanisms to provide psychological support to patients and their supporters. This range of service meant that each patient could access a service that was relevant to their particular needs.
- Waiting times for appointments and examinations were short. The hospital met the referral to treatment (RTT) waiting times for non-admitted NHS patients.
- Patients received the results of their diagnostic imaging examinations in a timely manner.

Good

Outpatients and diagnostic imaging

- There were systems to ensure that patient complaints and other feedback were investigated and reviewed. Appropriate changes were made to improve treatment, care and the experience of patients and their supporters.

Service planning and delivery to meet the needs of local people

- The provider told us Epsomedical Limited depended entirely on patient choice for its livelihood and therefore focused the hospital to be responsive to patients needs and ensure this was at the forefront of planning and delivering care. This meant the local population had choice as to where they could receive their care and treatment and the provider was focussed on their needs.
- The outpatient department was open from 8am to 6pm Monday to Friday. Patients told us they had been offered a choice of times and dates for their appointments.
- The unit has occasional clinics on a Saturday when the level of service dictated, for example ophthalmology clinics. This ensured local people could access services without undue waits.
- The outpatient department provided a health screening service which provided an appropriate range of tests and examinations based on clinical need. We looked in six sets of patient's records which indicated this was being completed. Reports went to patients and their GP if further investigations were required.

Access and flow

- A legal requirement by NHS England gives patients the right to access services within a maximum waiting time. This applies to NHS funded patients only. Epsomedical Limited met the target of 92% of referral to treatment (RTT) waiting times for patients beginning treatment within 18 weeks of referral for each month in the reporting period April 2015 to March 2016.
- The RTT waiting times for non-admitted patients beginning treatment within 18 weeks of referral were abolished in June 2015. However Epsomedical Limited met the target of 95% before the targets were abolished. Above 95% of patients began treatment within 18 weeks of referral throughout the rest of the reporting period (June 2015 to March 2016).
- Between April 2015 and March 2016 Epsomedical Limited demonstrated a strong performance in RTT as well as diagnostic and cancer waiting times. These results were discussed at the quarterly clinical quality review meetings with the main commissioner.
- From April 2015 to August 2016 the unit performed 6,017 diagnostic imaging procedures. The highest usage was x-ray which accounted for 60%. Other services were plain ultrasound (23%), dual-energy x-ray absorptiometry (9%) and transvaginal ultrasound (8%). Dual-energy x-ray absorptiometry is a means of measuring bone mineral density and transvaginal ultrasound examines female reproductive organs.
- Epsomedical Limited audited the reception waiting times for Cobham Day Surgery on a monthly basis April 2015 to March 2016. The average waiting time for a patient's appointment was 10 minutes. During the inspection two patients told us the maximum they ever waited was 10 minutes.
- Epsomedical Limited had a patient pathway from referral to discharge. Referrals were received by the schedulers in medical records (based at Cobham Day Surgery) and triaged by the clinical director and the compliance manager. There was a two week wait for appointments and were these were sent to the schedulers to allocate as a task on the computer system. However, if the referral was urgent this was emailed to the scheduler to allocate promptly. The scheduler booked patients into the appropriate clinic using an eight week roster system and ensured the relevant diagnostic tests would be available on that day. If an x–ray test was required patients were booked in 20 minutes before their appointment time with the consultant. After the consultation letters were dictated and outsourced to be typed. When they were returned they were uploaded to the patient's notes and the patients GP was informed. We were told this happened within 24 hours.
- Patients told us they were happy with the speed at which they had received their appointments.

Meeting people's individual needs

- The outpatient department had seven consultation rooms, one treatment room and a waiting area.
- We saw a variety of health-education literature and leaflets in the reception area. Some of this information was general in nature while some was specific to certain conditions.

Good

Outpatients and diagnostic imaging

- The outpatient and diagnostic imaging departments shared a waiting area and the main reception. We saw adequate seating available at a variety of heights and space available for patients to wait in wheelchairs. The hospital had several wheelchairs available for patients to use if required.
- Staff could tell us how they would access translation services for people who needed them. However we were told these were rarely needed.
- We did not see any leaflets in any other languages apart from English. However staff told us these were rarely needed and they could access leaflets in other languages if required, from a central database.
- We saw the signs advertising the hearing loop in reception which meant staff could communicate with those with hearing aids more effectively.
- Epsomedical Limited had an equality and diversity policy to ensure the Equality Act 2010 was embedded in the operations of the unit, and an equality report was submitted to the NHS commissioner. The unit, under NHS contract, was obliged to accept all qualifying referrals received and could not discriminate in terms of selection of patients.
- Staff received training on respecting equality and diversity in their mandatory training. At the time of inspection 100% of staff had completed the course and we saw records of this.
- Patients who were living with a learning disability or dementia were identified by staff when the referral was triaged. Staff told us if applicable, the appropriate individualised care and support was provided.
- Patients who were bariatric (severely obese) or who had mobility problems were also identified by staff when the referral was triaged. The unit had couches and chairs which were limited to a maximum weight. Couches in the consulting rooms were limited to a maximum weight of 225kg and chairs in the waiting areas limited to 158kg.
- The equipment in the diagnostic department was not designed to lower to accommodate a person with mobility problems. These patients would be informed the hospital would not be appropriate for them and referred to another provider.
- The waiting areas for the outpatients and diagnostic imaging departments had seating areas with refreshments, a television and magazines available for waiting patients and their supporters.
- The unit did not take referrals for patients under the age of 18. However there was a small play area for children in the waiting room, who may be visiting with patients.
- There were two rooms signposted as changing rooms allocated for the diagnostic imaging department. The changing rooms had access directly to the diagnostic imaging department which reserved patient's privacy and dignity. However one room was used as a store cupboard by the outpatient department.

Learning from complaints and concerns

- The Epsomedical Limited recognised there may be occasions when the service provided fell short of the standards to which they aspired and the expectations of the patient were not met. Patients who had concerns about any aspect of the service received were encouraged to contact the hospital in order that these could be addressed. These issues were managed through the complaints procedure.
- CQC directly received one complaint in the reporting period (April 2015 to March 2016). This was in September 2015.
- The unit had six complaints in the reporting period April 2015 to March 2016. No complaints had been referred to the ombudsman or an independent adjudicator. The assessed rate of complaints (per 100 inpatient and day case attendances) was below the rate of other independent acute hospitals CQC hold data for.
- Two of the complaints related to the outpatients department and referred to timekeeping of appointments in the department. During the inspection we saw the complaint process and outcome for a complaint relating to the outpatient department. A patient had raised a complaint about the provision of eye drops. This had caused a revision of patient literature and the production of ophthalmic advice flow charts.
- Complaints could be made verbally or in writing directly to the organisation, via the website or by NHS Choices. The complaints manager made a written record of verbal complaints.
- Information on how to make a complaint was available in leaflet form or on the website. Staff were aware of how to direct patients who would like to raise a complaint or concern.

Good

Outpatients and diagnostic imaging

- The compliance manager was responsible for the management of complaints over both sites. They coordinated the investigation and liaised directly with the complainant. The complaints were investigated by the most appropriate management leads.
- Complaints were discussed at the monthly management board meetings where the nature, response and outcome of the complaint were reviewed. We saw minutes of meetings which confirmed this. The reporting of complaints also formed part of the compliance agenda at the MAC meetings.
- Staff received feedback regarding complaints at team departmental meetings as well as on an individual basis.
- The Epsomedical Limited complaints policy set out the relevant timeframes associated with the various parts of the complaint response process. An initial acknowledgement was required within two working days and a full response within 20 working days. If a complainant was unhappy with the outcome by the hospital they were given the information of who to take the complaint to if they remained unhappy with the outcome. Private patients would be signposted to an independent adjudicator and NHS patients to the NHS Ombudsman.
- During the complaint investigation the process was monitored to ensure timescales were adhered to and responses provided within 20 working days. If a response was not able to be provided within this timeframe a holding letter was sent so they were kept fully informed of the progress of their complaint. During the reporting period April 2015 to March 2016 one complaint to Epsomedical had an extension time of one day which was agreed with the complainant. In all other complaints the provider met the target response times.
- All complaints information was retained within a paper file, with copies retained electronically and also stored in the hospital information management system.
- All complainants received a final response letter which encouraged them to contact the complaint manager if they were not satisfied with the outcome.
- We reviewed a total of five complaints files at Epsomedical Limited and found they had been appropriately investigated in a timely manner. We saw that complaints were initially acknowledged in writing and a full response was provided at the conclusion of the investigation which addressed the concerns raised.

Are outpatients and diagnostic imaging services well-led?

Good

We rated the services good for well-led. This was because:

- The management structure at the hospital meant there were clear lines of leadership and accountability.
- The senior management team were highly visible and accessible across the hospital. Staff described an open culture and said managers were approachable at all times.
- All staff were proud of the work they did at the hospital. Staff had a good understanding of the vision for the development of their services.
- Staff spoke highly about their departmental managers and the support they provided to them and patients. All staff said managers supported them to report concerns and their managers would act on them. They told us their managers regularly updated them on issues that affected the separate departments and the whole hospital.
- Governance processes were evident at departmental, hospital and corporate level. This allowed for monitoring of the service and learning from incidents, complaints and results of audits.
- Staff asked patients to complete satisfaction surveys on the quality of care and service provided. Departments used the results of the survey to improve services.
- The hospital had a risk register and was reviewed at the governance committee meetings.

Governance, risk management and quality measurement for this core service

- Epsomedical Limited had a corporate strategy in place. This governance framework ensured an effective organisational structure that supported the delivery of services and minimised the risks across all areas of business.
- The management board was responsible for corporate governance and approved all related documentation. The compliance manager was responsible for its implementation.
- The policies, plans, guidance and risk assessments were stored for easy access in the policies library of the group's intranet which we saw.

Good

Outpatients and diagnostic imaging

- There was a robust system of governance. The group's board met monthly and discussed clinical governance, incidents, complaints and the risk register. We saw the meetings agreed organisational aims and communicated these objectives to staff through medical advisory committee (MAC) and departmental meetings.
- Clinical quality and governance issues were reviewed at the six monthly MAC meetings. This involved a high level of engagement from the consultants. The MAC was responsible for ensuring there were robust systems and processes in place in relation to governance and assurance.
- The information discussed at the board and MAC meetings were cascaded to the wider team through separate departmental and clinical meetings. We saw the meetings of the clinical staff which took place every six months. These were chaired by the clinical director and all clinical staff were encouraged to attend. Clinical issues, appraisals, audit feedback, recruitment, training, incidents and complaints were discussed.
- A structured audit programme supported the hospital to ensure patient safety was at the forefront of service provision. Actions were monitored locally and within sub-committees and board meetings. These ensured lessons could be learnt and actions had been completed.
- The provider was required to submit data to the Private Healthcare Information Network (PHIN) by 1 September 2016, as required by the Competition and Markets Authority, a market investigation into private healthcare. We were told the financial director had been attending PHIN provider forums since 2015. All of the hospital's day case activity was fully coded in accordance with the NHS Data Dictionary and was ready to submit. The hospital was prepared to submit an NHS funded dataset if required.

Vision and strategy for this this core service

- The vision of Epsomedical Limited was for the hospital to provide patients with consultant-led care in a suitable environment with high standards of care.
- We were told the priorities for the following year included building up the core services, development of an interactive website where patients had access to their records, consolidation of the management team to create strength in more depth and improve relationships with local NHS bodies and finding opportunities for collaboration.
- We saw the clinical services were joint ventures between the clinicians and the hospital, recognising that both teams must work as a team with common objectives. The provider aimed to provide clinicians with the support they required to plan and deliver services effectively.
- The hospital had an appraisal policy to ensure that all staff understood their objectives and how they fit with the departmental and hospital objectives and vision. Staff we spoke with showed awareness of the aims and objectives of the organisation and its vision and values

Leadership / culture of service

- The outpatients and diagnostic imaging department reported to the compliance manager who reported directly to the managing director.
- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities in all areas of the outpatient and diagnostic imaging services. Staff told us they could approach immediate managers and senior managers with any concerns or queries.
- Staff saw their managers every day and told us the executive team were visible and listened to them. Any changes made were communicated through departmental meetings, newsletters and emails.
- Staff told us the unit was a good place to work, everyone was friendly, they had sufficient time to spend with their patients and they were proud of the work they did.
- The management team met daily. This meeting presented the opportunity to discuss daily key performance indicators, incidents, raise concerns and share successes.
- The rate of outpatient health care assistant (HCA) vacancies was above the average of other independent acute providers. As of April 2016 there was one whole time equivalent post vacant giving a vacancy rate of 33%. There were no vacancies for nurses.
- There was no staff turnover for registered nurses working in the outpatient departments in the reporting period April 2015 to March 2016. For the same period there was a 22% staff turnover for HCA's which was higher than the average turnover rate in other independent acute hospitals CQC hold data for.

- There was no sickness reported for nurses in the outpatient department during the period April 2015 to March 2016. The rate of sickness for HCA's was below the average of the other independent acute providers CQC hold this type of data for apart from the period July to October 2015.

Public and staff engagement

- The unit monitored patient satisfaction in all areas of its service delivery. Patient feedback was obtained via an electronic patient satisfaction service. There were paper forms available in the unit and electronic systems available via NHS Choices and through the Epsomedical Group website. The feedback was analysed by the management team and discussed at board level where the impact on service delivery was discussed. We were told the information was fed back to staff through team meetings and individually where appropriate. Information was published in the quality account and on the website and disseminated to the clinical commissioning quality team. Service development was built around the outcomes of this information and formed part of the revalidation process for staff.
- Staff competency feedback was collected in the patient satisfaction survey as well as letters and cards received from patients. These compliments were circulated to the relevant staff to ensure they were aware of the positive feedback received.
- We saw the results of the Epsomedical Limited staff survey 2016/17. The results were generally positive. As a place to work 53% were either extremely likely or likely to recommend Epsomedical, and 94% were extremely likely or likely to recommend Epsomedical as a place for treatment. However, only 18% of staff agreed senior managers involved staff in important decisions.
- The hospital had forums for staff communication. This included departmental meetings, bulletin boards and a monthly company newsletter which was issued following management board meetings.
- Staff told us managers shared information via email and newsletters. We saw noticeboards displaying information about infection prevention and control, health and safety, safeguarding and lessons learned from incidents and complaints.

Innovation, improvement and sustainability

- Epsomedical Limited had one layer of management and the composition of the management meant individual members were familiar with all aspects of the business. Decisions taken at board level could immediately be implemented as actions were allocated to those present and systematically followed up.
- Epsomedical Limited had a computer system which enabled them to manage operations on all sites from offices in Cobham Day Surgery. The computer system incorporated clinical outcomes, rostering, payroll, medical records, stock management, resource management, patient pathway tracking, management reporting as well as traditional clinic management functions. The system was in use and being developed to allow much greater insight into the performance of the units, clinicians, staff and managers. The system, in the future, will allow patients to access their electronic medical records and appointment log via the Epsomedical Group website. This will update the patient experience and help further streamline the administrative process.

Outstanding practice and areas for improvement

Outstanding practice

- The provider had direct access to electronic information held by community services, including GPs. This meant that unit staff could access up-to-date information about patients.
- Epsomedical Limited had invested in bespoke, integrated IT systems to ensure efficient management of staff, finances, other resources, clinical activity and governance.
- Specific procedures were separated by gender, with females undergoing the procedure on one day and males another day to ensure compliance with the Department of Health's same-sex accommodation guidance

Areas for improvement

Action the provider MUST take to improve

Action the hospital MUST take to improve:

- Introduce systems to ensure the checking and availability of anaesthetic equipment.
- Introduce a robust system for the reconciliation, storage and monitoring of medicines in the surgery department.
- Introduce processes to ensure compliance with the 'fit and proper person' requirement.

Action the provider SHOULD take to improve

Action the unit SHOULD take to improve

- Consider how to raise awareness of the complaints procedure for both staff and patients.
- Review processes on assessing pain to ensure they meet best practice.
- Take action to be assured all cleaning schedules are implemented and monitored.
- Improve awareness of the duty of candour obligation amongst the management team.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. (g) the proper and safe management of medicines. Systems in place to ensure safe management of medicines were not sufficiently robust or comprehensive. There were ineffective systems for the checking and reconciliation of medicine stock levels and some medicines were not stored in original packaging. CD registers were not always completed legibly.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment 12(2) without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include– 12(2)(f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs. Associated CQC guidance states “Sufficient equipment and/or medical devices that are necessary to meet

Requirement notices

people's needs should be available at all times and devices should be kept in full working order. They should be available when needed and within a reasonable time without posing a risk."

There was not a specific difficult intubation trolley, which contained specialist equipment for use in a difficult airway.

Anaesthetic machine logbooks were not fully completed both logbooks with evidence of daily pre-use checks.

An anaesthetic breathing circuit attached to the anaesthetic machine, it was labelled last changed in May 2016.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors Fit and proper persons: directors 5. 5(1) This regulation applies where a service provider is a body other than a partnership. 5(2) Unless the individual satisfies all the requirements set out in paragraph (3), a service provider must not appoint or have in place an individual— (a) as a director of the service provider, or (b) performing the functions of, or functions equivalent or similar to the functions of a director. The management board were not aware of this requirement or have a process in place to ensure compliance with this regulation and to ensure all board level staff met the requirements of "fit and proper person".