Epsom Day Surgery

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
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 Epsom 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 services of surgery and outpatients and diagnostic services as good, and the hospital overall as good. We rated well-led as required improvement as there were no processes to ensure fit and proper persons were employed at board level which met the relevant regulations.

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.
- 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 patients had access to suitable refreshments, including drinks, and were not fasted pre-operatively longer than was necessary.
- Care was delivered in line with national guidance and the outcomes for patients were good when benchmarked.

Summary of findings

- 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 the 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.

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

Importantly, the provider must:

- Introduce processes to ensure compliance with the 'fit and proper person' requirement.

In addition the provider should:

- Introduce a robust system for the reconciliation, storage and monitoring of medicines.
- Consider how contemporaneous safety record checks of anaesthetic machines are maintained.
- Improve awareness of the duty of candour obligation amongst the management team.

Professor Sir Mike Richards Chief Inspector of Hospitals

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	Good	• 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. However we also found: • 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 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.
Outpatients and diagnostic imaging	Good	• The unit had systems and to keep patients free from avoidable harm. Staff were aware of how to report

Summary of findings

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 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 and waiting times met national targets.
- Managers were visible, approachable and effective. There were systems and processes in relation to governance and quality assurance.

Summary of findings

Contents

Good

Epsom Day Surgery

Services we looked at

Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Epsom Day Surgery

Epsom Day Surgery is operated by Epsomedical Limited. It is a private day surgery and outpatient unit in Epsom, Surrey, although 99% of the work undertaken is on behalf of the NHS. The service originally opened as part of an adjacent GP surgery. A new day surgery suite opened in 1997 when Epsomedical Limited took over the running of the unit which primarily serves the communities of Cobham and Epsom but it also accepts patient referrals from outside this area. The unit does not treat children.

The hospital has had a registered manager in post since January 2011, and has a designated Controlled Dugs Accountable Officer who is 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 February 2014 and we did not identify any problems at that 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.

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 40 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 Medical Advisory Committee. We spoke with a wide range of staff including nurses, radiographers and administrative and support staff totalling 17 personnel. We also spoke with 11 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 11 sets of patient records. We visited all the clinical areas at the unit.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Good

Surgery

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

Information about the service

Epsom day surgery unit is part of Epsomedical Limited (Epsom Day Surgery and Cobham Day Surgery) it carries out a variety of different procedures including ophthalmic (eye), general, urology, dermatology and endoscopy (examination of the inside of the body by using a lighted, flexible instrument called an endoscope) procedures.

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

There were 2,428 day case episodes of care recorded at the unit between April 2015 and March 2016 of these, less than 1% were funded via non-NHS means.

The most common procedure undertaken in this period was gastroscopy (examination of the upper digestive tract). Gastroscopy accounted for 464, or just over 19% of, all procedures. Cataract (clouding of the normally clear lens of eye) surgery was the second most commonly performed procedure and accounted for 382, or nearly 16% 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 8am and 6pm.

The unit has a ward, one main operating room, a shared endoscopy and recovery room, an anaesthetic room and a waiting area with nine chairs. There is a shared room where endoscopies are undertaken and patients are recovered after their procedure. In addition, there are separate decontamination facilities for endoscopy. There is a ward area, which provides pre and post-operative care.

The theatre has laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination). A mixture of plastic surgery, hand surgery, general surgery, eye surgery and dermatology (skin) procedures, gynaecology and general surgery are undertaken in this theatre.

We visited all clinical areas during our inspection. We spoke with ten members of staff including nurses, doctors, allied health professionals, administrative staff and the executive team. We spoke with six patients and received 30 patient comment cards with feedback from patients who had undergone surgery at the unit. We reviewed three sets of patient records and a variety of unit data for example, meeting minutes, policies and performance data.

Good

Surgery

Summary of findings

We found surgical services were good for the key questions of safe, effective, caring, responsive but required improvement for well led. This was because:

- Staffing levels and skill mix were planned and reviewed to keep people safe at all times. All clinical areas had an appropriate skill mix during shifts.
- Staff were clear about their responsibilities to report incidents and there was a culture of learning from incidents that was promoted.
- The unit had effective systems to assess and respond to patient risk. This included the assessment of patients to ensure only patients who the unit could safely support received treatment.
- Staff were aware of safeguarding and were clear about their responsibilities to safeguard people at risk.
- Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation.
- Feedback from patients and those close to them was positive. Patients were treated with dignity, respect and kindness. Patients told us they felt supported.
- Patient consent was recorded in line with relevant guidance and legislation.
- Leaders modelled and encouraged cooperative, supportive relationships among staff. We saw examples of good team working within the unit.

However, we also found:

- Systems to ensure the monitoring, and availability of medicines were insufficient.
- Leaders were not clear about their roles and their accountability for ensuring directors met the 'fit and proper person' regulation.

Are surgery services safe?

Good

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

We rated safe as good because:

- Patients were risk assessed to ensure only those suitable received treatment.
- Staff reported incidents, took appropriate actions and learning was shared. Staff understood their responsibilities to raise concerns and report incidents.
- Staff told us that 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 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.
- All clinical areas were equipped to provide safe care and were visibly clean. Regular infection control audits were completed and monitored.

However:

- Systems to ensure the monitoring, and availability of medicines were insufficient.
- The checking of anaesthetic and emergency equipment was not always carried out effectively to ensure it was ready for immediate use.

Incidents

- The unit had not reported any 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. The unit reported no serious incidents between April 2015 and March 2016 as none had occurred.

- The unit had an incident report writing policy dated 2016 and staff used an electronic incident reporting system. Staff could all describe the process for reporting incidents, staff gave examples of times they had done this. All staff we spoke with had confidence in the incident reporting process.
- The unit reported six clinical incidents between April 2015 and March 2016, surgery reported 100% of all unit wide clinical incidents. The unit reported no incidents as resulting in severe harm, 100% of incidents resulted in moderate harm.
- For the same time period (April 2015 and March 2016) the assessed rates 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 at the unit 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.
- Staff in theatre told us about an incident occurred two weeks prior to our inspection and explained how it was discussed at a safety briefing, this ensured all staff were aware of the incident and any learning discussed.
- From November 2014, NHS providers were required to comply with the Duty of Candour (DoC) Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The duty of candour is a regulatory duty which 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. Operational staff understood their responsibilities with regard to the duty of candour legislation and we found the responsible manager ensured the duty was considered and met when investigating safety incidents.

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

- 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.
- We saw staff complying with infection prevention and control policies. For example, we saw four members of staff wash their hands and five 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.
- We observed ward staff adhered to the 'bare below the elbow' policy. Bare below the elbow means clinical staff were not wearing long sleeves, jewellery on wrists or fingers and no false nails. Staff, used personal protective equipment, such as disposable aprons and gloves.
- 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. Clean linen was stored appropriately and readily available on the ward and in theatre.
- The theatre and endoscopy/recovery room was visibly clean, and there was a safe 'flow' from clean to dirty areas to minimise the risk of cross contamination of equipment. The unit used single use equipment where possible.
- 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 six 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. 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.
- There were daily cleaning schedules in theatres, anaesthetic rooms, recovery and the ward area and we saw these were fully completed.
- 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.
- Hand hygiene audits in February 2016 showed 90% overall compliance with hand hygiene and 100% for compliance with correct technique.
- In an infection control audit undertaken at Epsom Day Surgery between October 2015 and December 2015, the overall score achieved was 94%. This was better than the target score of 85%.The report also highlighted areas for improvement for example inaccessible location of hand sanitising gel and two torn pillowcases.
- 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. 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.
- We saw there were no cleaning schedules in communal areas, for example in patient toilets this meant it was not possible to know when areas were last cleaned.
- In the main operating theatre there was an anaesthetic breathing circuit attached to the anaesthetic machine, it was labelled last changed in June 2016.This contravened 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". This was an infection control issue as bacteria may have accumulated between July 2016 and September 2016.The circuit had not been changed by the end of our inspection.
- We observed staff cleaning equipment was clean, however it was not marked with a sticker to confirm this. This meant staff did not have assurances equipment before use.

Environment and equipment

- The ward had a portable resuscitation trolleys for adults. The trolley contained medication and equipment for use in the event of a cardiac arrest. We saw daily check sheets completed for all trolleys to ensure equipment was available and in date. The resuscitation trolleys all had tamper evident tags to alert staff to any potential removal of equipment. We checked 47 items on the resuscitation trolley and three were out of date. This meant the sterility and function of these items could not be assured.
- The items on top of the trolley including the defibrillator were checked daily and the whole contents of the trolley checked monthly. This ensured emergency equipment was in date and available for use.
- 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.
- Surgical instruments were compliant with Medicines and Healthcare products Regulatory (MHRA) requirements.
- Electrical equipment had been safety tested, stickers showed when the equipment was next due for testing. This included blood pressure and cardiac monitors, anaesthetic machines as well as operating tables. We checked 15 electrical items and we found stickers on all equipment, which had undergone testing in the last 12 months. We checked over 45 consumable (disposable equipment) items and all were within date.
- Staff could access the equipment they needed and said they had sufficient equipment to care for patients
- 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.
- We inspected the gas manifold compound that housed the piped medical gas supply. This was located outside the building. Appropriate signage was in place to notify people what was contained within. The compound was secure and 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 three cylinders, which were in date and labelled.
- The unit's engineer told us there was a unit generator that was tested monthly. This ensured there was a backup supply of electricity if the main electricity supply failed.
- There were two collections and deliveries of instruments a day in theatres and an instrumentation coordinator who ensured relevant equipment was available.
- Theatres had a 'difficult intubation' trolley which contained equipment for use when a patient's airway was difficult to manage. We saw there was a monthly cleaning and checking procedure, this ensured equipment was clean, in date and ready for use.
- We attended a staff briefing prior to the start of a surgery list, we saw attention was taken to ensure the required implants were available.

- In the theatre, we checked the anaesthetic machine logbooks for the anaesthetic machine. We saw staff had not fully completed the logbook 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 machine worked safely. We spoke to a member of staff regarding the lapses in the checking process. They explained 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. This ensured an accurate record of checks was maintained.
- There was a room that was labelled as an anaesthetic room however; there was a desk and chair in the room. Staff explained the room was not used as an anaesthetic room as patients' were anaesthetised in theatre, and the room was used as a consultation room. There was a room, which was labelled as 'dirty utility', but the room was actually a storeroom. This could cause confusion for staff that were not familiar with the environment.

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 noted 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 no signed agreement. However the provider assured us at no time was the service delivery affected and there was no 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 medicines were stored safely and securely in line with relevant legislation for the safe storage of medicines.
- We checked temperature monitoring charts for the medicine fridges in both theatres and endoscopy room. The records showed staff had monitored the temperature of both fridges daily in the last month. 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.
- Staff told us that if they needed advice regarding a medication, they would either ring the pharmacy department at the NHS unit or they would access the British National Formulary (BNF).
- We saw eye drops being administered to a patient, it was done using the correct method, the patient was informed of what to expect and we saw it had been documented correctly.
- We checked the controlled medicines (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 medicines 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 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, 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 medicines.

Records

- There was an electronic patient record (EPR) system in use at Epsom 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.
- Some of the patient records was 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 of records and prevented the unauthorised access of patient records.
- Patients completed a paper based pre-assessment questionnaire and the information was transferred to the EPR.
- We saw there were a variety of risk assessments used, for example infection control risk assessments and patient pressure area assessments.
- 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 were no safeguarding concerns reported to CQC in the reporting period (April 2015 to March 2016).
- Safeguarding policies and procedures were in place to ensure that staff understood their responsibilities to protect vulnerable adults and children. The unit's 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.
- There were posters in the patient waiting area, which gave details of who patients or relatives could contact if they had concerns.

Mandatory training

- Mandatory training was outsourced to an external agency and 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.
- We saw the training records for staff, which were included within their appraisal (excluding medical staff) for mandatory training. Which showed that nearly 98% of clinical staff were compliant with mandatory training this was better than the unit target of 85%. This data was only available for the provider overall and was not site, or service specific.
- 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.
- 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 two team briefings, which were 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 we witnessed the consultant surgeon checking the eye implants. 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 three patients' MEWS charts. Staff had completed all three 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).
- There was one unplanned return to the operating theatre for the same time period.
- 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.
- We saw there were a variety of risk assessments used, for example infection control risk assessments and patient pressure area assessments.

Good

Surgery

- 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 observed at a team briefing there were problems identified with three of the patients. One patient's blood test result revealed it was not safe to undertake the operation, this was discussed amongst the team and surgery cancelled. Another patient was due to undergo an operation on their eye however, the forename on the diagnostic eye tests did not match the patient's correct name. The staff arranged for the diagnostic tests to be repeated and a member of staff escorted the patient. This demonstrated thorough safety checks were undertaken and gave assurances that the correct eye test matched the correct patient. The operating list order was changed and agreed by the team to reflect the changes. The remaining patient had an infection and the consultant surgeon said it was not safe to continue with the operation and cancelled the operation. We saw both patients who were cancelled were fully informed of the reasons and a treatment plan and review date was agreed prior to them leaving the unit. These incidents demonstrated how staff were able to respond to and minimise risks.
- We reviewed three 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.

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 between 1:5 and 1:6, this was better than the RCN recommendations.
- The use of bank and agency nurses (20%) operating department practitioners (16%) and HCA's (21%) 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

Surgical staffing

- The unit management team told us they had 48 consultants working with agreed practicing privileges at Epsom. This related to consultants in post on 1 April 2016 with more than 12 months service.
- There was an Epsomedical Limited (Epsom Day Surgery and Cobham Day Surgery) practising 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 practising privileges.

Good

Surgery

- 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 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

- 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 discussed pain relief with patients and provided information on the type of pain relief they could expect to receive as part of their procedure. Staff also gave information leaflets about their specific type of procedure.
- 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.

Evidence-based care and treatment

- Care and treatment took account of 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.
- 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.
- Staff completed venous thromboembolism (VTE) assessments in accordance with NICE clinical guideline 92 '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.
- 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.
- The unit performed World Health Organization (WHO) 'five steps to safer surgery' checklist audits. This meant there were adequate assurances that the WHO checklist was undertaken consistently and in line with national guidance.
- 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. These meant patients were informed regarding pain relief prior to their procedure.
- We spoke with three 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 obtained 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 was had 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.
- An additional audit was also carried out by a podiatry (treatment and prevention of diseases of the foot) consultant as part of data collection across three domains of which an assessment of pain relief was one of them.

Nutrition and hydration

- There was a robust process 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 were no unplanned readmissions 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.
- 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 complication rates were in line with national averages.
- 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 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 there was an improvement in the patients' symptoms post-surgery.
- All patients who underwent a general anaesthetic received a follow up phone call between 24 and 72 hours after discharge. Epsomedical Limited 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%).
- 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 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.

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.
- 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 appraisals took place and staff told us they had received an annual appraisal. Records showed 100% of staff had an appraisal in 2016.
- 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 would be discussed at the Medical Advisory Committee meetings. We saw evidence of this in meeting minutes.

- The unit provided data that demonstrated that one doctor had their practising privileges suspended between April 2015 and March 2016.
- There was a nurse endoscopist who had undertaken a nationally recognised endoscopy practitioner programme. The nurse worked at Epsom Day Surgery and a local NHS trust who undertook their appraisal. We saw the staff record to demonstrate the correct checks had been undertaken to ensure the nurse was competent to undertake the role.

Multidisciplinary working (in relation to this core service only)

- The surgical service demonstrated multidisciplinary teamwork at the unit with comprehensive record keeping and good communication. Patients' individual needs were considered during pre-admission discussions, with treatments planned to meet these.
- 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 who and how to contact GP's and district nurses if required

Seven-day services

- Epsom Day Surgery was open Monday to Friday between the hours of 8am and 6pm. 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
- 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.
- In an endoscopy questionnaire undertaken in April 2016, 100% of patients confirmed they had received written information, which explained their procedure.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The unit had a consent policy 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.
- Surgeons gained consent from patients for surgery. Information about the procedure was given to patients at their initial visit for assessment.
- We reviewed three 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.
- In an endoscopy audit undertaken by the unit in April 2016, ninety five percent 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.
- 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:

Good

Surgery

- People were treated courteously and their privacy was maintained. Patients were able to make informed decisions about the treatment they received.
- 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 provider received three items of rated feedback on the NHS Choices website between April 2015 and March 2016, one patient was extremely unlikely to recommend and two were extremely likely to recommend the unit to friends and family.
- 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 30 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 the recovery windows were covered to protect patients' privacy.
- We received 30 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: "Everything was considerate caring and generally excellent" and "The staff were all wonderful, they treated me as an individual and with care and respect"
- 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 patients' dignity, respect and confidentiality was maintained.

Understanding and involvement of patients and those close to them

- Patient comment cards stated "Everything was explained in easy understandable terms" and staff were amazing friendly, kind and explained each step of the way"
- These comments reflected patient centred care and patient individual needs were taken into consideration.
- We spoke with six 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. They told us they received full explanations of all procedures and the care they would need following their operation.
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place.

Emotional support

- Sufficient time was allocated for the pre- assessment appointment to allow patients time to discuss any fears or anxieties.
- We saw staff providing emotional support to patients who were worried or anxious.
- Staff demonstrated sensitivity towards the emotional needs of patients and their relatives.
- There were notices on walls in the unit, which gave information regarding a variety of local support groups.
- 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.

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.
- The senior staff in theatres reviewed operating lists in advance. This ensured there was sufficient time to arrange all the necessary staff and equipment to ensure appointments were not delayed or cancelled.
- We saw the theatre and ward facilities were appropriate for the services provided and met the needs of the local community.
- GP's been 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 29 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 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 to 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 submitted a 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

- 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.
- 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.
- For patients whose first language was not English, telephone translation facilities were available. In preoperative assessment, staff could change the colour of the paper on the patient leaflets if patients had eyesight problems. Patient information leaflets could be printed from a database in different languages.
- Staff told us patients living with learning difficulties or additional needs would also be 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.
- Staff gave us an example of this, a patient living with a learning difficulty attended the unit prior to their procedure to familiarise themselves and feel more relaxed. The staff bought a toy for when the patient came in for their procedure in order to distract and occupy the patient. The patient came in immediately prior to their scheduled procedure time to minimise time waiting for their procedure.
- For patients' with hearing loss, a hearing loop was available 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 there was a waiting area for patients with nine chairs, a television and reading material to occupy patients whilst awaiting their procedure.

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, 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. This stipulated 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 would be given the information of how to do this and to whom to if they remained unhappy with the outcome.
- Between April 2015 and March 2016, the provider met all target response times.
- The unit management team told us complaints were dealt with in a timely and open manner with dialogue encouraged between the concerned parties. One-to-one facilitated meetings were encouraged if the complainant felt comfortable or a mediator may be appointed to facilitate.
- Complainants were kept fully informed of the progress of the complaint.
- 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.
- Staff received feedback regarding complaints via the team departmental meetings and on an individual basis when part of 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.
- CQC directly received no complaints in the reporting period (April 2015 to March 2016).
- We reviewed a sample of complaints; they demonstrated patients had been acknowledged appropriately, investigated and patients were agreed of the outcome within the specified time frames unless agreed otherwise with the complainant
- Epsomedical Limited 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.
- The provider was not able supply details of the core services that the complaints related to. The provider kept detailed records of complaints for the whole service provided by Epsomedical Limited.Staff were

able to give us examples of complaints and resolutions. For example, a new telephone system had been installed to reduce the amount of time that patients wait for their calls to be answered.
- All of the patients we spoke with told us they had no complaints about the care and treatment they had received at the unit.

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 modelled and encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. Staff said managers were available, visible, and approachable.
- Openness, honesty and transparency were evident throughout the service.

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. Staff told us t 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 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.
- Staff demonstrated the unit values and behaviours in the care they delivered. All staff we spoke with were passionate about the service they provided and believed they consistently put the patient first.

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 communicated 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 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 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 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 that 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 Clinical Commissioning Group (CCG) and from local GP's.
- We reviewed the Epsomedical Limited 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 the provider had systems in place 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 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

- 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 that 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.
- 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. Some staff understood their responsibilities with regard to the duty of candour legislation. However, we were not assured the executive team where familiar with the duty or their responsibility to ensure the requirement was adhered to although the responsible manager ensured the duty was considered and met when investigating safety incidents. This meant patients might not be informed or receive an apology if a notifiable safety incident 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 given consideration as to how they might meet this requirement.
- We saw leaders valued and respected staff. Staff generally felt valued and told us leaders were visible and approachable. Staff told us they felt supported by their managers and colleagues.
- We saw staff worked well together and respected each other and worked as a team.

Good

Surgery

- 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.
- Staff morale was good with staff supported on the ward and in the theatre department. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience.
- In the Epsomedical Limited staff survey 2016/17 76% of staff said they were extremely likely or likely to agree with the statement that patients were Epsomedical Limited top priority.

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's 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 were 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.
- There was a close relationship with Clinical Commissioning Groups (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

- 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 Limited is the provider for both Epsom and Cobham Day Surgery units. The units are run jointly and the staff cover both sites. Therefore some of the data is not site specific.

Epsom 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 vast majority of patients are NHS funded. Epsomedical Limited carries out minimal private work, which represents less than 1% of their activity. There were 13,877 outpatient attendances in the reporting period April 2015 to March 2016 at Epsom Day Surgery. Of these, 99.9% were NHS funded and 0.1% were other funded.

Referrals are accepted for the outpatient department for adults above the age of 18 only.

The outpatient department has three consulting rooms. 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), rheumatology (disorders of the joints, muscles and ligaments) and gastroenterology (disorders of the stomach and intestines).

The outpatient department provides restricted ultrasound (the use of high-frequency sound waves to create an image of part of the inside of the body) testing relevant to podiatry (disorders of the foot, ankle and lower extremity) only. Other diagnostic testing, for example MRI and CT are outsourced services to other providers. These services were not part of this inspection.

We spoke with and observed the care provided by seven members of staff including nurses, health care assistants, consultants, administrators and managers. We spoke with five patients. We looked at eight sets of patient notes. We made observations ofthe environment and equipment staff used.

As part of our inspection, we looked at unit 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.Start here...

Good

Outpatients and diagnostic imaging

Summary of findings

We found the outpatient and diagnostic imaging services at Epsom 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. 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 service 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 unit 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 record the minimum and maximum temperatures of medication fridges and ambient room temperatures where medication was stored.

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 changes in practice that took place. Staff gave us examples of how they reported incidents and the feedback they received. 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.
- We found patient's records were legible, complete and accurate. There were systems to ensure records were stored securely.
- The unit had sufficient numbers of appropriately trained staff to provide safe care to patients. Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances.

However:

- The unit did not monitor and record the medicine fridge or ambient room temperatures on a regular basis and record action taken which meant that medicines may not be in optimum condition when used.

Incidents

- There had not been any never events reported in the period April 2015 to March 2016. Never events are serious events that are wholly preventable, where guidance or safety recommendations that provide strong protective barriers are available at a national level, and should be 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.

Good

Outpatients and diagnostic imaging

- There were no clinical or non-clinical incidents reported in the outpatient department in the period April 2015 to March 2016 as none had occurred.
- 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. Staff were able to give us examples of incidents that had been reported in the past.
- We saw reported incidents elsewhere at the unit 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, 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. We reviewed a sample of unit wide clinical incidents, patient's notes and root cause analysis, and saw staff had applied the duty of candour appropriately
- Staff said the dissemination of information was through electronic communications and their attendance at staff meetings.

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 unit.
- 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.
- All the areas we visited in the outpatients department 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 the unit was open and where actions had been taken, this was recorded.
- The unit audited the cleaning areas on a monthly basis with the cleaning subcontractor. We saw the evidence of these audits and the actions planned. The unit was audited 8 September 2016 and an action plan was raised regarding the dusting of high levels areas not being fully completed. This area was rechecked and resolved on 13 September 2016.
- The outpatients department did not have carpets in clinical rooms. 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 requires 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 Limited audited the sharps bins in June 2016. Overall there was good compliance however there was some areas in need of improvement. Epsom Day Surgery were 100% compliant in all areas except in one consulting room the temporary closure was not in the correct safe position. 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 Epsom Day Surgery infection control audit found the unit was compliant with a score of 94%, which was better than the unit target of 85%. 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 patient trolleys were found to be dusty, fabric chairs were in use and alcohol rub was not easily accessible in some areas. The audit was updated in July 2016, which highlighted areas which had been achieved. The action highlighted as not complete, but on schedule, was the replacing of the wipeable fabric chairs.

Environment and equipment

- The consultation rooms were equipped with a treatment couch and trolley for carrying the clinical equipment required. Each room had equipment in 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.
- The three consulting rooms had patient couches. The electrical testing of these were recorded as due May 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 unit when the service was due and the unit did not keep a record of this. The unit recognised this was an issue and was 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.
- 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 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.
- 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.
- Epsom Day Surgery did not have a pharmacy service on site. The pharmacy service was provided by the local NHS unit who visited when required. All medicines were ordered via the local NHS unit pharmacy.
- No controlled drugs (CD's) were kept or administered in the outpatient department.
- 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 unit 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.
- Consultants administered medicines in the outpatients department and these were accessed by the nurses and health care assistants who held keys. Medications were kept in a lockable cupboard which was secured to the wall. Only authorised staff had access to keys to the cupboard.
- 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.
- Medicines management regulations state minimum and maximum temperatures of locked medicine refrigerators and ambient room temperatures are to be checked and recorded daily when a department is in use. We saw the record sheet of the checks was displayed in the room. This stated the temperatures were to be recorded each working day the department was open. Additionally if the temperature was recorded as above 250 centigrade this must be reported to the appointed practitioner in charge. In August 2016 the temperatures should have been recorded for 24 days and we saw this was recorded for only 13 days. On 22 August, the temperature was recorded as 25.40 C with no action documented. This meant the effectiveness of the medicines could not be assured. For September 2016, the temperatures had only been recorded for two days and these showed the temperature as 25.20 C with no action recorded. We asked the management about this who told us the high temperatures were reported to the pharmacy department, the unit had a service level agreement with, and they advised no action to be taken. We saw the email correspondence to confirm this. However, no action was recorded on the record sheet to inform staff that action had been taken.

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 eight sets of patients records. We saw records were complete, legible and signed. They contained letters, results of diagnostic tests, discharge letters and the record of consultations and nursing treatment.
- We saw the quality audit trail record book for the decontamination for medical instruments used in ophthalmology. All records were appropriately completed.
- 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 Epsom and Cobham 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 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

- There had been one safeguarding concern reported to CQC from April 2015 to March 2016 as a statutory notification.
- 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 unit.
- 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

- 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.

Good

Outpatients and diagnostic imaging

- All nursing and HCA staff in the outpatient department 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.
- We saw the reception area had a hazard spillage kit readily available. This was for use in the event of spills involving hazardous materials would be contained to prevent spread of the material to other areas. Staff had received training in how to use the kit and we saw records which indicated staff checked the kits weekly to ensure they were ready for use.
- Transfer arrangements to associated unit 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 written instructions on whom to contact if they required support or information during opening hours and when the unit was closed. Clinical nurse specialists in dermatology and ophthalmology were available for advice and support.

Staffing

- Epsomedical Limited used an electronic rostering system for calculating staffing requirements to support the outpatient department.
- 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 unit told us they had 48 consultants working with agreed practicing privileges the Epsom site. This related to consultants in post at 1 April 2016 with more than 12 months service.
- We saw the Epsomedical Limited practicing 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 regulation19 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.
- Epsomedical Limited employed 16 whole time equivalent (WTE) registered nurses and five WTE health care assistants (HCA) and operating department practitioners 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 units 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.

Major incident awareness and training

- Epsomedical Limited had a disaster handling and business continuity plan dated 2016. 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 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%.
- Staff attended annual fire drills which were organised by the adjacent GP surgery. We saw evidence of this. Staff described what action to take in the event of a fire. This included the computer system which had a separate document enabling information about all patients and staff in the unit that needed to be accounted for. However, there was confusion regarding the testing of

fire alarms. Staff at the unit told us the fire alarm was tested weekly by staff at the adjacent GP surgery. However, when we spoke to staff there, they said that only the fire alarms relating to their sections of the building were tested and we reviewed documents to support this. This meant the fire alarms were not being tested. We brought this to the attention of the relevant manager who took immediate steps to reinstate weekly fire alarm testing at the Epsom Day Surgery Unit.

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.
- In the outpatient department, staff demonstrated how they could access NICE guidance and relevant policies on the unit's computer system.

Pain relief

- In the outpatient department doctors could prescribe pain relieving medicines if required.
- The podiatry consultant carried out an audit across both Epsom and Cobham 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 unit 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. Epsomedical Limited benchmarked itself against comparative data from local trusts. We saw the monthly activity returns submitted and saw that these targets were being met. The unit had regular review meetings where results were discussed with reference to how they could develop practices to improve upon services delivered. The unit audited patient outcomes by providing clinical governance reports to the management board, medical advisory committee (MAC) and other specialist groups.
- The unit collected outcome data for cataract operations. For example this allowed the unit to check the accuracy of lens power calculations and astigmatic (visual impairment) control and to monitor possible complications. We saw the results of the audit showed the unit was better than the national average.

Good

Outpatients and diagnostic imaging

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.
- 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 competencies. 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 they were renewed. We saw all staff had current professional registration where this was required.
- The Epsomedical Limited encouraged staff to enhance their qualifications where this matched operational requirements. Nursing staff told us they had access to local and national training and in the Epsomedical Limited staff survey 2016/17, 80% were satisfied with their personal development. This contributed to maintaining their registration with the Nursing and Midwifery Council (NMC).
- All the staff we spoke with had received an annual appraisal. In 2015 and 2016, 100% of staff in the outpatient department had received an 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.
- We saw the results of the Epsomedical Limited staff survey 2016/17. This reflected 39% of staff felt their appraisal helped to improve their job while 33% of staff said it did not.
- We saw the unit 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 unit 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 practising privileges was recorded in the minutes of the MAC notes.

Multidisciplinary working (related to this core service)

- Staff told us they worked well together and had good communication with other health care professionals and administrative staff. We saw staff engage with each other in a professional and courteous manner.

Seven-day services

- The unit was open 8am to 6pm Monday to Friday. Seven day services and out of hours services were not provided.

Access to information

- 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 unit were able to access the PACS system which was demonstrated to us.
- Staff in the outpatients department could access a shared drive on the computer where policies and unit wide information was stored. Staff demonstrated this to us.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Epsomedical Limited 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 unit policy. We saw the forms outlined the expected benefits and risks of treatment so patients could make an informed decision.
- Epsomedical Limited 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.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring for the service 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.
- Patient's surveys and assessments reflected the friendly, kind and caring patient centred ethos. Our observations of care confirmed this.

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 unit's chaperone policy.
- Data was submitted to the Friends and Family Test (FFT) for NHS patients only. The 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 units FTT score was 99.3% for their 2015/16.
- 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 unit.
- During the inspection we asked patients to complete feedback forms to describe their experience of the outpatient department at the unit. We collected 10 completed cards which were all positive about the unit and services received. Comments included "treated by all staff with dignity and respect", "environment is great and friendly", "staff always polite and efficient" and "excellent service I cannot fault anything".
- We spoke with five patients during our visit. One patient told us "I couldn't ask for better" and another told us "the staff make me feel very relaxed".

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.

Good

Outpatients and diagnostic imaging

- 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 service 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 unit met the referral to treatment (RTT) waiting times for non-admitted NHS patients.
- 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 unit to be responsive to patients needs and ensure this was 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. The unit has occasional clinics on a Saturday when the level of service dictated. For example ophthalmology clinics. Patients told us they had been offered a choice of times and dates for their appointments.
- 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. 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.
- Epsomedical Limited 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 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).
- Epsomedical Limited audited the reception waiting times for Epsom Day Surgery on a monthly basis from April 2015 to March 2016. The average waiting time for an appointment time was 10 minutes. The clinics we observed ran to schedule. We did not see any patients wait more than five 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 referrals 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

were 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 three consultation rooms and one was used as a treatment room. The waiting area in the main reception was shared by the unit. We saw adequate seating available at a variety of heights and space available for patients to wait in wheelchairs. The unit had wheelchairs available for patients to use if required.
- 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.
- Staff told us how they accessed 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 enabled those who used hearing aids to communicate more easily.
- Epsomedical Limited had an equality and diversity policy to ensure the Equality Act 2010 was embedded in the operations of the unit. This included a section in the staff handbook to explain staff responsibilities. 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 saw the 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 waiting area in the main reception for the outpatients department 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 selection of toys for children in the waiting room, who may be visiting with patients.

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 unit in order that these could be addressed. These issues were managed through the complaints procedure. 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. All complaints information was retained within a paper file, with copies retained electronically and also stored in the unit information management system.
- 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.
- 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.
- No complaints were received directly by CQC in the reporting period (April 2015 to March 2016).
- Epsomedical Limited received 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.

- Two of the complaints related to the outpatients departments at Epsomedical Limited 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 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 complaint was escalated to a further stage the complainant was 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 treated at the hospital, 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 Limited 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 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 unit meant there were clear lines of leadership and accountability. The outpatients department reported to the compliance manager who reported directly to the managing director.
- The senior management team were highly visible and accessible across the unit. Staff described an open culture and said managers were approachable at all times. They told us their managers regularly updated them on issues that affected the separate departments and the whole unit.
- All staff were proud of the work they did at the unit. 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.
- Governance processes were evident at departmental, unit 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.

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.
- 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 unit, 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 unit had an appraisal policy to ensure that all staff understood their objectives and how they fit with the departmental and unit objectives and vision. Staff we spoke to showed awareness of the aims and objectives of the organisation and its vision and values.

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 implementation.
- The policies, plans, guidance and risk assessments were stored for easy access in the policies library of the intranet which we saw.
- 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 communicate 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 unit 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 unit's day case activity was fully coded in accordance with the NHS Data Dictionary and was ready to submit. The unit was prepared to submit an NHS funded dataset if required.

Leadership / culture of service

- The outpatients 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 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 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.
- 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 units 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 July to October 2015.

- In the Epsomedical Limited staff survey 2016/17, 76% of staff were extremely likely or likely to agree with the statement that patients were the organisation's top priority.

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 Limited 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.
- The unit had forums for staff communication. This included departmental meetings, bulletin boards and a monthly company newsletter which was issued following management board meetings.
- 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
- 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 Limited 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.

Areas for improvement

Action the provider MUST take to improve

- Introduce processes to ensure compliance with the 'fit and proper person' requirement.

Action the provider SHOULD take to improve

- Introduce a robust system for the reconciliation, storage and monitoring of medicines
- Consider how contemporaneous safety record checks of anaesthetic machines are maintained.
- 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 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”.