Will Adams NHS Treatment Centre

Quality Report

Beechings Way
GILLINGHAM
Kent ME8 6AD
Tel:0333 200 1730
Website: willadamstreatmentcentre.nhs.uk

Date of inspection visit: 9 and 22 August 2016
Date of publication: 09/12/2016

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

Ratings

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

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

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

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

Summary of findings

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 the Will Adams NHS Treatment Centre (WATC) on 9 and 22 August 2016 as part of our national programme to inspect and rate all independent hospitals. The centre opened in 2005 and provides elective NHS services to people living in Rochester, Chatham and Gillingham in Kent. NHS treatment centres are private-sector owned and contracted by the local Clinical Commissioning Group (CCG) to treat NHS patients free at the point of use.

We inspected the two core services of surgery and outpatients and diagnostics and rated the centre overall as good.

Are services safe at this centre?

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

- There were clear, open and transparent processes for reporting and learning from incidents. Staff reported incidents and managers shared learning locally and within the wider organisation. Staff were aware of the duty of candour requirements and there were arrangements to meet these if required.
- Medical and nursing staffing levels met patients' needs. Staff completed a mandatory training programme and were competent to do their jobs.
- The centre was visibly clean and there were arrangements to prevent the spread of infection. The environment and equipment was well maintained and fit for purpose. Medicines were managed safely in accordance with legal requirements, although some documents related to medicines management were beyond their review dates. Patients' records were complete, stored securely and available when required.
- There were appropriate management arrangements for safeguarding with an identified senior lead. Staff received training in the safeguarding of adults in vulnerable circumstances and children to an appropriate level and knew what action to take if abuse was suspected.
- Patients were assessed to ensure there were no safety risks that would prevent them being treated at the centre. Patients were monitored to ensure early identification of any deterioration and there were suitable arrangements to deal with emergencies including transfer of patients to a local NHS hospital.

Are services effective at this centre?

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.

- Patients received care and treatment in line with national guidelines which was referenced in the corporate policies in use at the centre.
- Patient outcomes were monitored using national and local audit programmes and generally were in line with national averages. There were fewer transfers out to NHS hospitals than other independent hospitals and no unplanned readmissions within 28 days.
- Patients received adequate pain relief. They were not fasted pre-operatively unnecessarily and received food and fluid that met their needs.
- Arrangements for obtaining consent met legal requirements, including where patients lacked capacity to give consent themselves. However, the competency assessment documents policy was beyond the review date.

Are services caring at this centre?

By caring, we mean that staff involve and treat patients with compassion, dignity and respect.

Summary of findings

- Patients and those close to them were positive about their experience and we saw care maintained patients' dignity and privacy. The friend and family test results showed that 99-100% of patients would recommend the centre.
- Patients said they were supported emotionally and their care was discussed with them in detail.

Are services responsive at this centre?

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

- The centre worked with the local CCG's and other NHS providers to give local people a choice in where they received their treatment. Patients were able to access the service in a timely way with over 95% beginning treatment within 18 weeks of referral. Patients could book treatment and appointments at times that suited them.
- There were arrangements to meet the individual needs of patients. Patients underwent a pre-assessment process that ensured they met explicit referral criteria and were suitable for treatment at the centre and any individual needs were identified and planned for. The organisation had a dementia strategy implemented and patients were screened for dementia. There were arrangements to support people with learning disability and the centre was accessible to wheelchair users.
- There was a complaints process that was understood by staff and was publicised to patients. Complaints were appropriately investigated in a timely manner, response letters generally sent within agreed timescales and learning points shared.
- Interpreters could be booked if needed; the centre did not allow relatives to translate for patients in line with best practice. However, patient information leaflets were not available in other languages.

Are services well-led at this centre?

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

- Staff demonstrated an understanding and appreciation of the values and aims of Care UK and the centre. There were clear lines of leadership and accountability and staff had a good understanding of their responsibilities. There was visible leadership both at local and corporate levels and staff told us felt they felt supported by their managers. Staff were proud to work at the centre and there were high levels of work satisfaction.
- The centre acted on and made improvements from staff feedback. The feedback of patients was sought and the centre had an active patient forum which contributed to developments. The centre participated in local community events to raise awareness of the centre and its services.
- There was an appropriate governance structure which enabled the management team, and Care UK to monitor performance and benchmark this against the centre's peers. Information relating to quality and safety was disseminated throughout the centre to relevant staff. There were arrangements to identify and manage risks via risk assessments and a risk register although some departmental managers lacked clarity about the location of risk registers. We noted a number of corporate documents used at the centre had passed their review dates.

Our key findings were as follows:

- The centre had a good safety record, and there were systems to investigate and learn from incidents and complaints.
- The centre was visibly clean and well maintained, and that there were effective systems to prevent infection. Performance in relation to healthcare associated infection was good.
- There were sufficient numbers of staff with the qualifications, skills and experience to meet patients' needs.

Summary of findings

- Patients received care that was based on national guidance and experienced good outcomes from treatment.
- Patients received adequate pain relief and appropriate food and drink.
- Patients were positive about their experience and received care that protected their privacy and dignity. They received adequate information about their care and emotional support.
- There were arrangements to safeguard children and adults in vulnerable circumstances and patient's individual needs were considered and met.
- Staff understood the values of the organisation. There was effective and visible leadership and governance and risk management structures and processes that assured the quality of care and safety of staff and patients.

We saw several areas of outstanding practice including:

- The provision for patients to liaise in person with the appointment schedulers to arrange their next appointments prior to leaving the treatment centre.
- Real time theatre monitoring that enhanced the centre's ability to provide an effective and efficient service, which reduced delays and inconvenience to patients.

However, there were also areas where the provider needs to make improvements.

The provider should:

- Improve document control related to medicines management protocols and patient group directions (PGDs) to ensure that staff are referring to up to date versions.
- Display posters relating to the chaperone policy and highlight the choice for the patient to request a member of staff as a formal chaperone.
- Make arrangements to ensure patient information leaflets are available in other languages.
- Ensure departmental managers are clear and aware of the location of the departmental risk registers and risk assessments.

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		• There were systems to protect patients from avoidable harm which included the reporting and investigation of incidents. Patients were protected from the risk of infection and medicines were managed safely in line with relevant legislation. • There were sufficient numbers of appropriately skilled staff to meet patients' needs who treated people with kindness while maintaining their dignity. • Care was delivered in line with national guidelines and best practice and its effectiveness monitored. Patient's experienced good outcomes from their treatment. • The leadership team were well respected and were assured of quality and safety of care through appropriate governance arrangements.
Outpatients and diagnostic imaging	Good		• There were systems to ensure incidents were reported and investigated, and learning points were implemented. Infection control practices, medicines management and the management of records adhered to relevant legislation and national guidance and protected patients from avoidable harm. • There were appropriate staffing levels and staff were competent to do their jobs. They provided compassionate care that met individual's needs. • There were governance arrangements which monitored the quality and safety of care. Feedback was gathered from patients and used to improve the service. There was good engagement with the local community • People could access care and waiting times met national targets. • Staff were positive about the department's leadership, were aware of the centre's vision and values and felt supported to put them into practice.

Summary of findings

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Good

Will Adams NHS Treatment Centre

Services we looked at
Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Will Adams NHS Treatment Centre

The Will Adams NHS Treatment Centre (WATC) opened in 2005, and is sited in a business park on the outskirts of Gillingham. It provides elective NHS services to people living in Rochester, Chatham and Gillingham in Kent and serves a mixed population.

NHS treatment centres are private-sector owned and contracted by the local Clinical Commissioning Group (CCG) to treat NHS patients free at the point of use. Care UK Clinical Services Limited took over management of the centre in 2008. Care UK is the largest independent provider of NHS services in England, and in addition to other healthcare activities operates nine other NHS treatment centres.

WATC is a two-storey complex originally constructed as a sports centre. It is located just off a major trunk road and access is enhanced by free onsite parking. The upper storey contains management, stores and administration offices. Ground floor accommodation is fully accessible for disabled people and comprises:

- Outpatient facilities with four consulting rooms
- Ophthalmology suite with three consulting rooms
- Two operating theatres and an endoscopy suite
- Facilities to clean, pack and sterilize surgical instruments
- A 17 bed day surgery unit including a four bed recovery unit

Patients are referred by their GP and are able to choose the centre as part of the NHS 'Choose and Book' process. WATC provides surgical and diagnostic services to adults who are generally healthy and who do not have significant co-morbidities (the presence of one or more diseases or disorders in addition to the current diagnosis). Services offered include:

- Minor orthopaedic surgery, including arthroscopy, osteotomy and minor hand and foot procedures.
- Ophthalmology (eye diseases), in particular cataract procedures, ocular plastic and vitreous body injections.
- General Surgery, hernia repair, varicose vein repairs, removal of skin lesions.
- Urology and minor procedures including cystoscopy
- Endoscopy; Gastroscopy, Colonoscopy and Flexi-sigmoidoscopy.

In addition, WATC hosts the Medway Maritime Hospital Endoscopy service once a week and a team from the National Bowel Screening Programme three times a week, but does not manage these services.

Outsourced services include imaging (CT, MRI, Ultrasound and X-ray), nerve conduction studies and pathology. The centre shares resources such as pharmacy, medical staff and some managers with the North East London NHS Treatment Centre, which is managed by the same provider.

Our inspection team

Our inspection team was led by Shaun Marten, Inspection Manager, Care Quality Commission. The team comprised of CQC inspectors with senior nursing and pharmaceutical backgrounds and specialists including:

- A consultant in vascular surgery
- A specialist in adult nursing
- A specialist in outpatient nursing

Why we carried out this inspection

We carried out a comprehensive inspection of the Will Adams NHS Treatment Centre (WATC) as part of our national programme to inspect and rate all independent hospitals.

Summary of this inspection

How we carried out this inspection

Our inspection took place over one extended day, 9 August 2016, during which we observed services. We also reviewed a wide variety of documents relevant to the running of the service supplied prior to our visit and during the inspection. During our visit, we made observations of care and made checks on the environment and equipment used by patients.

We spoke to a range of staff in a focus group discussion as well as during the visits. This included consultants, nurses and operating department practitioners, healthcare assistants, technical and administration staff and a volunteer. We spoke with patients and relatives and reviewed cards collected from CQC comment boxes placed in reception prior to and during our visit.

In addition to our main inspection, we undertook an unannounced visit on the 22nd August 2016, during which we checked equipment and staffing levels, observed interactions between patients and staff, and reviewed care and treatment.

Information about Will Adams NHS Treatment Centre

During the period April 2015 to March 2016, WATC treated a total of 13,238 patients. Day-case attendances accounted for 37% of this activity (4,876) and 63% (8,362) attended outpatients. All patients were over the age of 18 and all were NHS funded.

In the same period the ten most common procedures performed were Phacoemulsification of lens (a treatment for cataracts - 2114), Gastroscopy (727), Colonoscopy (582), Injection into vitreous body of the eye (317), Excision of skin lesion (165), Sigmoidoscopy (155), Excision of lesion head and neck (137), Primary Repair of Inguinal Hernia (73), Carpel Tunnel (50) and Rubber band ligation of haemorrhoids (46).

WATC is led by a centre director and operations manager, who has operational responsibility for the facility. The Medical Director and the Head of Nursing have operational and professional responsibility for all clinical departments. The centre director had submitted an application to be registered manager and we were processing this application at the time of our inspection. There was an identified controlled drug accountable officer (CDAO).

All consultants are employed or contracted on a sessional basis. There were 32.4 full time equivalent (FTE) registered staff employed, including nurses, operating department practitioners, health care assistants, and 22.4 FTE support staff. Staff turnover and sickness absence rates for nurses, operating department staff and health care assistants were below the average when compared to independent acute hospitals for which we hold data. Although there were no vacancies for health care assistants, the vacancy rate for nurses working in inpatient departments and other staff is higher than the average when compared to other independent acute hospitals for which we hold data. However, there were no unfilled nursing shifts in the period January to March 2016.

During the year April 2015 to March 2016 we did not receive any direct complaints or whistle-blowing contacts. There were no safeguarding concerns reported to us. The centre received nine complaints, none of which were referred to the Ombudsman or the Independent Healthcare Sector Complaints Adjudication Service.

During the same year there were no Never Events at the hospital. Never Events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death. There were 90 clinical incidents reported within this year. None of these were reported to cause severe harm, and 4% were reported to have caused moderate harm. There were also 35 non-clinical incidents reported.

In the same period, there were no reported cases of meticillin resistant staphylococcus aureus (MRSA), Clostridium difficile (C. diff) or Escherichia coli (E. coli). These are serious infections which have the potential to cause harm.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Information about the service

Will Adams NHS Treatment Centre (WATC) is owned by Care UK Clinical Services Limited and provides day-case elective surgery to NHS patients in the following specialities: orthopaedics, general surgery, ophthalmology (eye surgery) and endoscopy. Patients are treated by sessional and directly employed consultants. The most commonly performed procedures between April 2015 and March 2016 were phacoemulsification of lens (cataract surgery, 2114 cases), gastroscopy (727 procedures), colonoscopy (582 procedures) injection into vitreous body (eye, 317 cases) and excision of skin lesion (165 cases). Outsourced services supporting diagnosis include magnetic resonance imaging (MRI), computerised tomography (CT) scanning, ultrasound, x-rays, nerve conduction studies and pathology.

Admission for surgery follows strict referral criteria and is for people aged 18 years and over who require routine non-urgent surgery. The treatment centre does not provide a service for patients who require overnight admission, although the centre opens late when required and transfer protocols are in place should a patient's condition unexpectedly deteriorate.

Between April 2015 and March 2016, there were 4,876 day-cases performed at the centre, all of which were NHS funded. The treatment centre has a day-case ward with 17 bed spaces and a four-bed recovery area. There are two operating theatres and an endoscopy suite, which is open Monday to Saturday. The centre has an on-site Central Sterile Services Department (CSSD) where surgical instruments are sterilised.

Our announced and unannounced inspection took place over two days. We reviewed documents supplied by the provider prior to our visit and made available during the inspection. During our visits, we observed care and treatment, and made checks on the environment and equipment. We visited the day-case ward, recovery area, operating theatres and CSSD.

We reviewed nine sets of patient records and we looked at policies and procedures, staff training records, audits and the environment and equipment.

We spoke with four patients, one relative, one volunteer and 21 staff in a variety of roles including managers, health care assistants, registered nurses, consultant surgeons, operating department practitioners, technicians and administrative staff. We also received nine completed comment cards.

Good

Surgery

Summary of findings

Overall, we rated the Surgery services at WATC as good because:

- Patients were protected from the risk of abuse and avoidable harm. There were effective systems for reporting, investigating and learning from incidents. Staff knew how to escalate key risks that could affect patient safety, such as safeguarding from abuse. Complaints about the service were carefully investigated and lessons learnt shared with staff.
- Staffing levels met patients' needs. Staff completed mandatory training and were competent to do their jobs.
- The centre was visibly clean and there were appropriate systems to prevent and control healthcare associated infections. Medicines were managed safely in accordance with legal requirements.
- The consent process for patients met national guidance and staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Staff responded compassionately when people needed help and support to meet their basic personal needs. Staff also respected people's privacy and confidentiality at all times. Patients' feedback through interviews and comment cards was positive.
- The centre monitored patient outcomes to provide assurance of the effectiveness of the service. Patients received care and treatment in line with national guidelines such as the National Institute for Health and Clinical Excellence (NICE).
- There was a clear governance structure in place with committees such as clinical governance, infection control, heads of department and risk management. There was clear and visible leadership provided by senior management and within the departments.

Are surgery services safe?

Good

We rated safe as good because:

- There were effective systems to report incidents. Incidents were investigated, monitored and reviewed. Staff gave examples of learning from incidents and understood the principles of duty of candour. Staff were aware how to report safeguarding issues and there were clear systems for responding to suspected or actual abuse.
- Levels of nursing and surgical staffing were adequate throughout the department to meet patients' needs and staff were up to date with their mandatory training. There were arrangements for managing medicines in line with legal requirements.
- Records were stored securely and were available for staff when needed. The content was current, legible, and comprehensive.
- The patient environment throughout the surgical service was fit for purpose and well maintained. The centre was visibly clean and staff followed hospital infection prevention and control practices, which were regularly monitored.
- Appropriate equipment was available and suitably maintained. Emergency equipment was available and tested to ensure it was ready for immediate use.

However:

- Centre volunteers had not been trained in safeguarding.

Incidents

- Staff reported incidents on an electronic reporting system. Staff confirmed they had received training about how to input incidents, the type of incidents that needed to be reported and who the incidents should be reported to. Staff confirmed they received feedback about incidents they had reported.

- Staff told us they received feedback about incidents at staff meetings and we saw minutes of meetings which confirmed this. We saw in the minutes that managers discussed themes or trends and shared lessons learned with staff.
- The centre reported no serious incidents or never events between April 2015 and March 2016. Never events are serious, largely preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.
- The centre had reported 95 Clinical Incidents between April 2015 and March 2016, of which 91% (86 incidents) occurred in surgery or inpatients. Of these, 82% were rated as resulting in no harm, 14% as low harm and 4% as moderate harm. These figures are all better than the averages for other independent hospitals we hold data for. The rate of clinical incidents had decreased since the second quarter of 2015. Out of 35 non-clinical incidents 43% occurred in surgery.
- Incidents were reviewed at monthly clinical governance meetings. Records form these meetings showed learning and changes to practices were made in response to incidents. Learning from incidents at other Care UK locations was also shared.
- The duty of candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm or death to patients or any other relevant person. Staff knew about the duty of candour legislation and 90% had attended training on this, which met the corporate target and matched other Care UK centres. We saw records that demonstrated the centre's duty of candour obligations were being met.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (blood clots forming in leg veins due to immobility). The centre submitted monthly data to the NHS, as this was part of the information required when treating NHS patients.
- The centre reported 99% to 100% screening rates in April 2015 to March 2016 for venous thromboembolism (VTE) and 100% for compliance with recording World Health Organisation (WHO) surgical safety checks We saw the results of the safety thermometer displayed in the staff rest area.The safety thermometer data indicated that there were no falls, pressure ulcers or catheter related urinary tract infections in the past three months.

Cleanliness, infection control and hygiene

- There no were no reported cases of meticillin resistant staphylococcus aureus (MRSA), Clostridium difficile (C. diff) or Escherichia coli (E. coli) in the period April 2015 –March 2016. These serious infections have the potential to cause harm.
- The centre staff followed their corporate 'Prevent and Control of Infection' policy (dated November 2015), which included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons, and spillage of body fluids.
- All areas we visited were tidy, visibly clean and uncluttered. This included higher-level dust traps such as door surrounds, window frames and curtain rails.
- Clinical areas did not have fitted carpets. Flooring was seamless, smooth, slip-resistant and provided with an easy clean finish. This complied with Health Building Note (HBN) 00-09: Infection control in the built environment (Department of Health, March 2013).
- We saw disposable curtains fitted on rails between bays and cubicles. Each had a label showing the date changed, which were within the last four weeks. Frequently changed disposable curtains helps to reduce the chances of germs passing from one person or object to another.
- Staff followed the local policy and procedure when scrubbing, gowning and gloving prior to surgical interventions. When a procedure had commenced, movement in and out of the operating theatres was restricted. This minimised the risk of germs contaminating a patient's skin or wound.
- Medical equipment and trolleys appeared visibly clean throughout the department, and staff had a good understanding of their responsibilities in relation to cleaning and infection prevention and control.

Good

Surgery

- We saw wall mounted dispensers for aprons and gloves in three sizes (personal protective equipment) and we noted hand-sanitising gel mounted on each bay dividing wall. Posters were displayed which explained hand washing technique in line with World Health Organisation guidance.
- Clinical wash-hand basins were installed in all clinical areas. These were medium or large integral back-outlet basins with mixer taps and no plugs. This complied with Health Building Note (00-10 (2013): Part C – Sanitary assemblies).
- We saw recent examples of completed infection control audits showing 100% compliance. These audits helped managers and staff to assess the effectiveness of their infection control measures and to identify any areas that required improvement.
- We saw evidence in the patient notes that staff screened high-risk patients for MRSA, such as those who had been in hospital previously and patients who had tested positive for the bacteria before. This was in line with Department of Health: Implementation of modified admission MRSA Screening guidance for the NHS (2014). MRSA and MSSA are infections that have the capability of causing harm to patients.
- The centre's Patient Led Assessment of the Care Environment (PLACE) audit for 2016 showed WATC scored 100% for cleanliness, which was better than the England average of 98%.
- All single-use items we saw were in date, such as syringes and wound dressings. Correct storage and stock rotation ensured the sterility of items was maintained and risks of cross contamination reduced. We saw these items being used once and disposed afterwards.
- We saw waste was separated and put in different coloured bags to signify the different categories of waste. This was in accordance with the Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health (COSHH) and health and safety at work regulations. All waste was kept in appropriately bins that were locked within a secure compound where they were accessed by the waste disposal contractor.
- We saw sharps bins available in treatment areas and correctly used in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The bins were secure containers, clearly marked and placed close to work areas where medical sharps were used. The bin labels included clear instructions for staff on safe disposal.
- We observed staff working in the endoscopy suite. We saw the endoscopes were leak tested and flushed through in the suite before guidewire cleansing and that instruments were decontaminated in an automatic endoscope reprocessor located in a dirty utility room. This was separated from the clean room and other parts of the theatre complex to help reduce the risk of cross contamination. Records were kept of detergents and disinfectants used and the whole process was monitored using a computerised tracking system.
- We also saw personal protective equipment (PPE), including disposable aprons, visors, gloves, theatre hats and masks, available to staff decontaminating endoscopes. We saw staff using PPE during endoscope cleaning to protect them from infection and we also saw staff washing their hands appropriately after cleaning to reduce the risk of contamination to staff and patients.
- The centre had its own sterile services department (CSSD). Staff in CSSD sterilised and undertook maintenance on medical devices, equipment and surgical instruments for use by healthcare professionals working in the operating department. A member of the CSSD attended the daily morning brief, to ensure surgical instruments were available for the day's operating list.
- We subsequently visited the instrument washing area in CSSD and were shown trays of surgical instruments being processed before autoclaving. We saw further evidence of the instrument tracking system as well as autoclave equipment checks and performance testing used to assure the instruments were cleaned effectively, decontaminated and packaged ready for use.

Environment and equipment

- The day-case ward and operating theatres were visibly clean, well maintained and free from clutter. The ward and recovery areas were spacious and comprised of individual bays with partitions and curtains to help preserve privacy. Reclining chairs were used in the day ward and theatre trolleys employed in the recovery area.

- Storage facilities within the centre for supplies were well organised and tidy. Consumable items were placed in marked storage bins, mounted on purpose-built racks that moved on casters. This meant the cleaners had easy access to the floor and walls in the store for routine and deep cleaning.
- None of the staff we spoke with had concerns about equipment availability and if anything required repair it was fixed quickly. Staff were aware of the process for reporting faulty equipment.
- Equipment safety checks were undertaken daily in theatres by the operating department practitioners (ODP's). This included checks of oxygen cylinders. The anaesthetic machines had a secondary check from the anaesthetist prior to each use. We saw examples of the checklist being used.
- We saw two resuscitation trolleys in the theatre and the day-case ward. Both trolleys were locked. Records showed the trolleys were checked daily. All drawers contained consumables and medicines in accordance with the checklist. We saw the consumables were in date and trolleys were clean and dust free. The automatic electrical defibrillator and suction equipment were in working order. This meant all items were ready for immediate use should an emergency occur.
- Patient couches, furniture and equipment were labelled with asset numbers and service or calibration dates. This helped to provide assurance that items were maintained in accordance with manufacturer recommendations.
- The Medicines and Healthcare Products Regulatory Agency's Managing Medical Devices (April 2015) states that healthcare organisations should risk assess to ensure that the safety checks carried out on portable electrical equipment are appropriate and reasonably practical. These include pre-use testing of new devices in addition to subsequent maintenance tests. We checked several devices in each of the areas we visited. These devices were labelled with the dates of the most recent electrical testing which provided a visual check that they had been examined to ensure they were safe to use.
- Alerts relating to patient safety, medicines and medical devices were cascaded across the surgical services and responded to in a timely manner. Staff showed us the alert folder on the day-case ward with, patient safety alerts and we saw the action points arising were completed within required timescales.
- The Patient Led Assessments of the Care Environment (PLACE) for 2016 showed the centre scored 98% for the condition, appearance and maintenance which is better than the England average of 93%.

Medicines

- In general, the surgical service had safe systems for ordering, storage and the administration of medicines. However, the Medicines Management Policy was due for review in April 2015, which meant staff had guidance which may not reflect recent changes in the applicable regulations or best practice. Local and organisation-wide audits were completed, which showed the centre complied with the current policy.
- We noted that 84% of staff had completed medicines management mandatory training, which was worse than the centre's target of 90%.
- The centre had a local medicines formulary, which staff could access through the Care UK intranet. This complied with NICE guidelines (MPG1): developing and updating local formularies (amended 2015). In the recovery area we saw a copy of the British National Formulary (BNF) Issue 71, the latest edition in print. This indicted that an appropriate level of reference materials was provided to staff involved in the ordering, supply and administration of medicines.
- We observed appropriate storage and record keeping of controlled drugs consistent with the Misuse of Drugs Regulations, 2001. There was a clear process for the day unit and theatres to order controlled drugs (CDs), although we noted the absence of a list of authorised signatories on site. We were told this was maintained by the pharmacy situated at the Northeast London centre which supplied CD's to the centre.
- Entries for the administration of CD on the unit had a secondary signatory as required by legal and regulatory standards including Nursing and Midwifery Council (NMC) Standards for Medicines Management. There was evidence of daily controlled drugs stock checks in the

day-case ward controlled drug register. Staff we spoke to were familiar with policies regarding the destruction of controlled drugs and we saw suitable drug destruction kits in the CD cupboard.

- We saw that medicines requiring storage in a temperature-controlled environment were held in designated drug fridges. These could be locked and incorporated digital thermometers with an easily readable display that allowed performance to be monitored. Staff undertook fridge temperature checks daily and recorded on a standardised form. Staff could describe the process of dealing with out of range temperatures and showed us the policy explaining the process, which included reporting it as an incident on the electronic reporting system
- As there was no pharmacy department on site, a service level agreement for collection and delivery of medicines was in place. Staff working in the department described the process for ordering medicines from the Care UK treatment centre in North East London.
- Prescription stationery was stored in a locked cupboard, within a securable room. Staff told us the room was locked when not in use and keys kept with a designated member of staff within the department. We saw a record of when a prescription had been issued. Two nurses signed each entry and there was evidence of monthly checks on the number of prescriptions. This is in line with NHS Protect, security of prescription forms guidance (2013).
- In an operating theatre utility room, we saw an orange-lidded sharps container being used for disposal of expired drugs. While access to the room was restricted, the lid itself was insecure and therefore presented a risk of misappropriation of the contents. The Department of Health (DoH) produced guidance on this topic in HTM07-01 – Safe management of healthcare waste (2013). According to the memorandum, containers for pharmaceutical waste must be secure with clear labelling and lids, both of which should be colour coded to facilitate segregation of waste. Blue colour coding is recommended in the document. We raised our concern with managers, who undertook to order new containers immediately. When we returned on our unannounced inspection, we were told these had been ordered and the centre was awaiting delivery.
- Medical gas cylinders held in the compressor room were all 'in date' and staff told us that the facility had just been inspected by the supplier (BOC), who advised that new warning signs were required. These were purchased and we saw them fitted when we returned on our unannounced visit.

Records

- The centre followed their corporate policy (dated August 2013), which included confidentiality of patient records, documentation by clinicians, length of time records were to be kept and patient records on discharge or transfer.
- We saw patient personal information and medical records managed safely and securely, in line with the Data Protection Act. When not in use, patients' notes were kept in a locked records cabinet.
- We saw the medical records of nine patients. All medical records were tidy with no loose filing, legible, dated and signed. This was in accordance with the centre's documentation policy.
- All records we reviewed were complete and up to date. Each patient had the appropriate care pathway documented.
- Staff told us that they had no difficulty in retrieving medical records in time for patient's admission. As an elective treatment centre, patients were referred by their GP or optician using either the NHS E-referral system or by letter or fax. At the point of accepting a patient, the centre checked for a minimum data set and if anything was missing, the schedulers contacted the referring practitioner for further information.
- Once the patient was accepted, the centre created a medical record using a computerised patient administration system. The notes were then tracked automatically, which helped the centre monitor the records. A contractor scanned the notes, which could then be accessed electronically if needed. This meant that if a patient subsequently returned to the centre, staff could rapidly access a copy while the documents were retrieved from the archive.

Safeguarding

- There had been no safeguarding concerns reported within the last twelve months.

- There was a corporate 'Safeguarding Children' policy (dated May 2015) and 'Safeguarding Vulnerable Adults' (dated January 2016) policy with defined responsibilities at local, regional and national levels. We saw posters on two notice boards displaying safeguarding contact numbers and a 'referral process flowchart', which meant that staff had ready access to clear instructions and advice should they have any safeguarding concerns.
- The centre had two safeguarding named professionals who led for safeguarding for both adults and children. This was an operating department practitioner supported by the head of nursing. We saw role descriptions, meeting notes and training records, which showed their activities. Staff we spoke with knew who the leads were for safeguarding, how to report concerns and when they would ask them for help or advice.
- Staff received training in the safeguarding of adults and children as part of their induction, followed by mandatory refresher training yearly. We saw examples of the training packages provided as part of an on-line induction and learning system. Safeguarding vulnerable adults training was undertaken every year for levels one and two. Data indicated 91% of staff had completed level one safeguarding vulnerable adults training and 88% had completed level two training, which met the corporate targets. These training levels were appropriate for the staff roles undertaken.
- In the centre, 86% of staff had completed level two safeguarding children training. The requirement for staff to attend level two training was in line with the Safeguarding Children and Young People – Roles and Competencies for Staff intercollegiate document (2014) as the centre did not treat children.
- The centre's safeguarding lead was trained to level four, which was higher than the minimum level three training detailed in the policy. The centre showed commitment to working with other organisations with regard to safeguarding and acted as the host for Kent Safeguarding Partnership meetings.
- We learned that four volunteer helpers, part of a new initiative by this centre had yet to undertake safeguarding training in line with corporate policy. When we returned on our unannounced visit, arrangements had been made for the volunteers to complete the on-line training package.

Mandatory training

- Mandatory training for all staff groups was made up of modules accessed through an on-line learning system. Mandatory training modules included equality and diversity, manual moving and handling, infection prevention and control and information governance. Other training was role specific, for example medical gas training, food safety and blood transfusion.
- The centre planned a half day every month with no clinical activity to allow for governance meetings, team meetings and mandatory and other training.
- We saw records which showed 96% of staff in the centre had completed their mandatory training, which was better than the Care UK target of 95%.

Assessing and responding to patient risk

- Records showed where staff had completed patient risk assessments. These included risk assessments for venous thromboembolism (VTE or blood clots) in line with NICE Clinical guideline CG92 (last updated June 2015). During our inspection, we looked at nine sets of notes, which showed correctly completed risk assessments.
- Pre assessment of patients was in accordance with British Association of Day-care Surgery (BADS). As part of the preoperative assessment process, patients completed a comprehensive Pre-Admission Medical Questionnaire (PAMQ which were reviewed at pre-assessment appointments. They were also used to assess the suitability of patients for surgery and to carry out health assessments such as an electrocardiogram (ECG). Depending on the information provided in the PAMQ, the pre assessment nurse carried out either a short telephone pre assessment for lower-risk surgery, or invited the patient in for a face-to-face pre assessment. The pre assessment nurses confirmed that if discussions at either a telephone or face-to-face pre assessment highlighted a potential safety concern, they reported the issue to the surgeon or anaesthetist.
- As part of the PAMQ, all female patients of childbearing age were asked the date of their last menstrual period

(LMP), to check their pregnancy status. On admission to the day-case ward, female patients had an additional pregnancy test performed. This was in line with the National Patient Safety Agency 2010 Rapid Response Report, which highlights the 'unreliability of LMP as a sole indicator of potential pregnancy'.

- The centre used the National Early Warning Score (NEWS), and escalation flow charts to identify patients whose condition was, or was at risk of, deteriorating. NEWS is a simple scoring system for physiological measurements, such as blood pressure and pulse, for patient monitoring. Observation of the nine records showed NEWS scores were correctly calculated at the required frequency.
- The centre used a 'quality-round document', to ensure their patients were safe and comfortable. The quality-round form included pain control, nutrition, falls risk and NEWS score. Quality rounds were undertaken every two hours for all day patients. This meant staff could anticipate any potential complications before they happened.
- The theatre team used the 'five steps to safer surgery' World Health Organisation (WHO) checklist to minimise errors in surgery, by carrying out a number of safety checks before, during and after surgery. The use and completion of the WHO surgical checklist was regularly audited by staff. We saw recent audits scoring 100%. During our inspection we observed one theatre team undertake the WHO checklist correctly and saw other patient notes, which showed the WHO check had been completed fully.
- Theatre staff had a daily morning safety meeting, which ensured all staff had up to date information about issues with scheduling or cancellations that might affect the operating lists on the day.
- The centre had a transfer agreement in place so patients could be transferred to the local NHS trust if needed. If a patient's health deteriorated, nursing staff were supported with medical input to stabilise a patient prior to transfer. We saw emergency transfer equipment available in the treatment area, such as a portable ventilator.
- Patients who received a general anaesthetic or sedation as part of their procedure as well as all ophthalmology patients received a follow-up phone call the next day from a clinical member of staff.

Nursing staffing

- The centre managers told us they had previously used a national staffing tool to decide the number of nurses required on shift, but found this too complex for their needs. The centre used a one nurse to five patient ratio. The nurse in charge was supernumerary to the numbers and was on duty on most day shifts.
- At the time of our inspection, we saw sufficient staff in the day-case ward area and theatre and on reviewing rosters for the last month noted that planned staffing levels matched staff on the day. Bank and agency staff were employed to make up any shortfall in numbers.
- The centre did not use any bank or agency health care assistants (HCAs) in the last year. The centre used between 9% to 10% agency nurses, which was lower than the average of other independent hospitals we hold data for.
- Senior nurses in the ward and theatre told us they held weekly planning meetings, which allowed them to assess the number of patients planned for the following week to ensure the centre filled all the shifts, and escalate and shortfalls in staffing. We saw examples of roster sheets and operating theatre activity spreadsheets used in these meetings.
- We observed one nurse handover, which was structured and provided consistent information, and included details of patients' needs, the time of operation and type of procedure, pain scores and starve times. This meant the nurses had sufficient information and patients would receive the care they needed.
- The centre complied with the recommendations of the Association for Perioperative Practice (AfPP) for the numbers of staff on duty during a standard operating list. We saw staffing rotas and planning spreadsheets that supported our observations.

Surgical staffing

- As a consultant-led service, the centre directly employed two orthopaedic specialists, two surgeons, six ophthalmologists, six gastroenterologists and eight

Good

Surgery

anaesthetists. According to the centre, some were employed full time and others on a sessional basis. Consultants did not work under practising privilege agreements. There were recruitment checks that ensured consultants suitability to work at the unit

- We saw information on rosters and notice boards that showed the operating consultant and an anaesthetist was always available while the centre was open. We were told that additional medical support could be called upon from outpatients if a clinic was running or if the medical director was working on site.
- Consultants from each speciality had agreed to have their contact numbers added to an out of hours on call phone folder held by a registered nurse identified on the off-duty rota. The after-hours number was included in the patient’s discharge instructions and the nurse responded to any concerns, telephoning the consultant for advice if needed.

Major incident awareness and training

- The centre has a business continuity plan (dated November 2015) in place in the event of potential emergencies. The plan covered major incidents such as how to respond in the event of loss of power, loss of staffing, adverse weather or flood. Staff were aware of the plans and managers spoke about an ingress of water during last winter, which tested the continuity plan.
- Staff and managers told us it worked well and gave positive examples of their response, such as patients being offered the option of executive transportation to the Northeast London centre for their procedure and then home, which minimised disruption and delay. Lessons were learnt and incorporated into the plans.
- Scenario based training events were held quarterly to help ensure staff responded appropriately to emergencies. Scenarios included collapse due to cardiac arrest or anaphylaxis and other topics such as fire drills and alarm tests. We saw records dated December 2015 and March 2016 supporting this.

Are surgery services effective?

Good

We rated the services good for effective because:

- Patients received care and treatment in line with national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges, such as Royal College of Anaesthetics. The centre monitored patient outcomes to provide assurance of the effectiveness of the service.
- The outcomes of surgical procedures were monitored and national comparisons showed good results.
- There were arrangements to ensure patients received adequate pain relief and to ensure they received appropriate food and drink. Preoperative starving was minimised in line with national guidance.
- There was a good multidisciplinary team approach to care and treatment. Staff had the right qualifications, skills and knowledge to do their job.
- Patients consented to care and treatment and when they lacked capacity to do so and staff were aware of their obligations under the Mental Capacity Act 2005

Evidence-based care and treatment

- Care and treatment was delivered to patients in line with the National Institute for Health and Care Excellence (NICE) and Royal College's guidelines, for instance the Royal College of Anaesthetics.
- Corporate policies were evidence based. We saw that Care UK policies referenced the national guidance on which they were based. For instance, the policy relating to the National Early Warning System cited NICE guidance - clinical guideline (CG) 50.
- Staff assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with venous thromboembolism: reducing the risk for patients in centre NICE guidelines CG92.

Good

Surgery

- NICE guidance CG65 for hypothermia: prevention and management in adults having surgery was followed, the patient's temperature was monitored before anaesthetic and then every ten minutes during surgery.
- Consultants confirmed that surgical procedures were in-line with best practice and. We saw evidence of this in the quarterly quality and governance assurance committee minutes (May 2016), which highlighted latest NICE guidance.
- Comprehensive care pathways were used for patients undergoing local and general anaesthesia. This included quality indicators of anaesthesia, management of pain and recommendations for the management post discharge complications.
- The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) quality assures all aspects of endoscopy units to ensure policies, practices and procedures are safe and compliant with national guidelines for endoscopy including staffing, training, decontamination, audits and patient's privacy and dignity. The centre had been JAG assessed as 'improvement required – level 1'. Managers said their accreditation was achieved but deferred until September 2016 to allow the centre to make improvements for final review. Full accreditation will provide the centre with independent assurances and benchmarking about the quality of its endoscopy service.

Pain relief

- There were arrangements to ensure patients received adequate pain relief. There was a pain assessment scale within the National Early Warning Score (NEWS) chart used within the hospital.
- Pain audits were carried out for both endoscopy and day surgery patients. They showed assessments were carried out and acted upon. We reviewed six sets of patient notes after their procedures which showed these had been completed.
- Pain score and assessment prompts were included in the 'quality round form' used by staff, to ensure their patients were safe and comfortable. Quality rounds were undertaken every two hours for all day patients. Patients told us nurses routinely asked them about pain as part of these rounds.
- In March 2016, 100% of patients who responded said that the staff had done all they could to control pain in the centre's electronic feedback questionnaire.
- We spoke with four patients who told us their pain was adequately managed. One patient told us their "pain was managed well" and another said that full explanations had helped.
- We saw patients were given information leaflets to take home which provided information on how to manage pain following discharge from hospital.

Nutrition and hydration

- As a day treatment centre, full catering services were not provided. We saw beverage machines in the waiting room area and staff serving drinks and pre-packaged snacks to patients from the day-case ward kitchen, which meant that patients could be served refreshments before being discharged.
- Staff followed guidance on fasting prior to surgery based on the recommendations of the Royal College of Anaesthetists. Patients received information about fasting in their preadmission pack.
- Patients at the centre who had fasted pre-operatively were required to eat and drink before they could reach the unit's discharge criteria. We saw this happened during our visit.
- Nutrition and hydration prompts were included in the 'quality round form' used by staff, to ensure their patients were safe and comfortable. Patients told us nurses routinely offered them drinks as part of these rounds and we saw this during our observation.

Patient outcomes

- Under a service level agreement with the local NHS trust, two patients had been transferred out to an NHS centre in the year April 2015 to March 2016 because of post-operative complications. The proportion of unplanned transfers was lower than other independent hospitals we hold this data for.
- There were no cases of unplanned readmission within 28 days of discharge in the reporting period.
- The centre undertook various clinical audits such as WHO safety checks, VTE, MRSA results, ophthalmic outcomes, peri-operative temperature audits and

endoscopy audits in line with JAG guidelines, some of which included pain and comfort scores, sedation and completion rates. Outcomes were reported to the CCG) monthly as part of the centre's key performance submissions.

- NHS patients having hip or knee replacements,varicose vein surgeryorgroin hernia surgerywere invited to fill inPatient Reported Outcome Measures (PROMs) questionnaires. The PROMs questionnaires ask patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation. The centre provided PROMS data for varicose vein surgery and hernias. Of the patients treated for groin hernia between April 2015 and March 2016, 39% reported their health had improved following surgery, 34% unchanged and 27% worsened. For varicose veins the figures were 36%, 20% and 44%. Hernia results were worse than the average for England and the varicose vein results were similar to national averages.

Competent staff

- Staff told us they received an annual appraisal when objectives were set and learning needs and further training was discussed and planned. Appraisals were linked to the centre's and Care UK's vision and values. We saw records that showed that 100% of staff had received a performance appraisal between April 2015 and March 2016.
- Staff were encouraged to undertake continuous professional development (CPD) and were given opportunities to develop their clinical skills and knowledge through training relevant to their role. In the 2015 staff survey, 65% agreed to the statement "I am able to access the right training when I need to" and 61% responded positively to "I have the opportunity for personal development and growth".
- We saw CPD folders for nursing staff and two for theatre staff as well as an online personal training record for a consultant. All certificates were up to date, for example life support and pain management, and competency assessments were completed.
- In addition, we viewed the induction and orientation records for two agency nurses and a student nurse, all of which had been completed and verified. We were told that a supernumerary induction process was provided for all new employees.
- We saw copies of the induction course content and programme provided to four "hospital volunteers" recruited as part of a new initiative by the centre.
- The centre checked the status of registered staff to ensure they remained registered and staff were supported in the revalidation process. We saw records that confirmed this.

Multidisciplinary working (in relation to this core service only)

- Throughout our inspection, we saw evidence of good multidisciplinary working in all areas. We observed positive interaction and respectful communication between professionals. We saw effective arrangements were in place for collaborative working between consultants, nursing and operating department practitioners.
- Our review of patient records, talking with members of staff, volunteers and patients confirmed there was effective multidisciplinary working practices that involved nurses, doctors, ODPs managers and technicians. Clinicians reported effective working relationships within the centre in a wide range of contexts. This included the management team, nurses, operating department practitioners (ODPs) and technicians and the availability of equipment
- Staff described the multidisciplinary team as being supportive of each other. Staff told us they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective. In the last staff survey 82% of respondents felt proud to work for Care UK, which supported this view.
- The preoperative assessment nurses told us how they liaised with anaesthetists and surgeons to co-ordinate preoperative investigations including confirming what assessments were needed and following up the communication once results were obtained.

Seven-day services

- The centre opened from 7.30 am – 7.00 pm Monday - Saturday. Tuesday evening sessions ran until 9.30pm. As a day surgery unit, no out of hours services were required.
- Comprehensive arrangements were in place to transfer post-operative patients to another hospital should their recovery be prolonged or to deal with any calls from patients out of hours.

Access to information

- Patient records were accessible on the wards and departments. Staff reported no concerns with accessing patients' records, including blood test and imaging results.
- GPs received information about patients' treatment promptly. Discharge summaries were sent electronically at the time the patient was discharged from the centre.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consultants obtained consent from patients for surgery. Initial discussions regarding consent were commenced by a consultant at the outpatient clinic. Once admitted, consent was reaffirmed with the patient by the operating consultant.
- Staff said they had completed training about the Mental Capacity Act 2005. Data provided by the centre showed a 94% compliance rate, which was better than the Care UK target of 90%. The centre followed their corporate 'Deprivation of Liberty Safeguards Policy' (dated April 2016), and corporate 'Consent to Investigation of Treatment' Policy (dated January 2016). Staff demonstrated knowledge of these policies and explained how they used them.

Are surgery services caring?

Good

We rated caring as good because:

- Patients and relatives feedback was consistently positive about the care provided from all of the staff at the centre. Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment. We observed interactions which showed staffwere welcoming, caring and supportive
- Patients felt supported and said staff cared about them. Staff responded compassionately when patients needed help and supported them to meet their needs.
- Staff were highly motivated to offer care that promoted people's privacy and confidentiality was respected at all times.

Compassionate care

- We observed staff being compassionate and caring. This was supported by the patients we spoke to as they expressed positive views about their experiences at the centre. We were shown patient feedback comments (May 2016) and a collection of cards of appreciation which further supported the views expressed to us. We received nine comment cards from patients who have recently had surgery at the hospital. All were very positive about the care and treatment they received.
- The day case ward consisted of partitioned bays with reclining couches in addition to recovery bays. Surgical lists were arranged to avoid mixed sex breaches (where females and males are treated and cared for on the same ward area).
- In Patient Led Assessments of the Care Environment (PLACE) assessments published August 2016 the centre scored 88% for the way in which staff supported the privacy, dignity and wellbeing of patients. This is better than the national average of 84%.
- The NHSFriends and Family Test (FFT) is an anonymous patient satisfaction survey created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. The centre scored 99% for inpatients. Data supplied by the centre showed consistently high scores for the day-case unit of99% - 100% over the last six months. Response rates varied in the same period from 54% - 27% against a national average of 40%. This showed patients were positive about recommending the centre to their friends and family.
- In Care UK's last staff survey, 94% of staff would recommend the centre to anyone needing care.

Good

Surgery

Understanding and involvement of patients and those close to them

- We saw staff introduced themselves to patients, explained their role and the examination that was about to be performed.
- All patients we spoke with told us their care was discussed in detail with them. Patients told us they were given time and were able to ask questions, and felt included in the decisions that were made about their care.
- We observed staff explaining discharge information and providing patients with support to ensure they had a good understanding of their procedure and onward care needs. Patients told us they had been provided information about their procedures at preadmission assessment appointments and that full information and explanations were given pre and post-surgery.

Emotional support

- Patients told us they felt able to approach staff if they felt they needed any aspect of support and this view was supported by remarks in the comment cards we read.
- Patients spoke highly about the ability of staff to reassure nervous patients. We talked to a relative of an elderly patient who had hearing loss and was anxious about an eye procedure under local anaesthetic. The consultant stopped preparations and made alternate arrangements for the patient to receive a general anaesthetic and for their daughter to accompany them during the start of the procedure.

Are surgery services responsive?

Good

We have rated responsive as good because:

- Access to surgical services was timely and patients could book procedures at a time to suit them. NHS patients were consistently admitted within the 18 week referral to treatment target.
- Information about the complaints procedure was available for patients and relatives. Staff had a good understanding of the complaints process, and complaints were discussed at monthly staff meetings.
- Patients were assessed prior to undergoing surgery and staff were proactive in meeting patient needs. Vulnerable adults, such as patients living with a learning disability or dementia were identified at the referral stage and appropriate steps were taken to ensure they were appropriately cared for. Staff planned daily to ensure patients were admitted and discharged in a timely manner.

However we found:

- While staff have access to a telephone based translation service, all written information including leaflets and signage was available in English only.

Service planning and delivery to meet the needs of local people

- The centre worked with the CCG) to provide local people with a choice of where they received care. Patient choice was demonstrated by being able to choose dates of appointments and surgery utilising the NHS E-Referrals system.
- In addition, the centre was hosting the 'one stop' Medway endoscopy service to help reduce waiting lists in the region and the national bowel screening service as part of preventative health measures for the local community.
- Managers told us they worked with neighbouring businesses to help preserve and continue the easy access from motorways and local roads. The centre offered free parking with additional access to public transport links.

Access and flow

- As a day unit, Will Adams NHS Treatment Centre (WATC) followed strict admission criteria and provided a service for patients aged 18 years or over who required routine non-urgent surgery. The treatment centre did not provide a service for patients who required overnight admission, although the centre opened late when required and transfer protocols were in place should a patient's condition unexpectedly deteriorate after surgery and they required overnight admission.

Good

Surgery

- The centre had exclusion criteria in order to ensure only suitable patients were treated. WATC's exclusion criteria was based on American Society of Anaesthesiologist (ASA) classifications that were designed to identify patients at higher risk of complications from the anaesthetic given during surgery. All referrals were screened during the referral and assessment processes and anyone who was pregnant or identified as ASA 3 (patients with severe systemic disease) were referred back to the NHS. Patients with a Body Mass Index (BMI) greater than 38 were excluded from procedures under general anaesthesia and anyone with a BMI of over 45 from local anaesthetic procedures. The effect of these exclusions meant that patients with heart and lung conditions (including sleep apnoea), unstable diabetes or receiving active treatment for cancer were not treated at the centre. Only those at the lowest risk classification were seen. We saw nurses using these criteria to ensure none of the exclusion criteria applied when assessing patients.
- Patients left the facility after an average stay of two hours. Staggered admission times were used to minimise the inconvenience of long waits.
- During our inspection, the theatre lists ran on time. The centre employed a real-time display system with screens in the operating theatre suite and ward nursing station. The information could be securely accessed by managers, which enhanced the monitoring, and planning of activity as the day progressed.
- Discharge letters were sent to the patient's GP on the day of discharge, with details of the treatment provided, follow up arrangements and medicines provided.
- There were 4,876 visits to the operating theatre between April 2015 and March 2016. The centre reported 145 cancelled procedures for non-clinical reasons in the last 12 months, however many of these were as a result of a single incident of an ingress of water. Of these, 97 patients were offered another appointment within 28 days of the cancelled appointment. We learned that those not offered an appointment within 28 days were for legitimate reasons.
- The treatment centre met national targets for patients waiting less than 18 weeks after referral for treatment.

Meeting people's individual needs

- All admissions were pre-planned so staff could assess patients' needs prior to treatment. This enabled staff to plan patient care to meet their specific requirements, including those relating to any cultural, linguistic, mental or physical needs. Theatre staff told us patients identified as high risk, such as diabetic patients, were scheduled for surgery at the beginning of the theatre lists in case they developed complications during their procedure.
- We saw nine patient records (six of which were post-procedure) and saw they included pre admission and pre-operative assessments that took into account individual patients' preferences.
- Patient Led Assessments of the Care Environment (PLACE) for August 2016 showed the centre scored 90% for dementia and 92% for disability; both better than the England averages
- The centre had a named nurse lead for dementia and we saw examples of a dementia resource folder on the day-case ward.
- Adults in vulnerable circumstances, such as those living with a learning disability or dementia were identified at the referral stage, and appropriate steps were taken to ensure they were appropriately cared for. "Helping hand" stickers were used to help easily identify patients requiring extra assistance and we found examples where the centre was quick to make adjustments such as ensuring they were accompanied by a relative or carer for their admission.
- We saw other features that were designed to help patients with sensory or mobility disabilities. For example, level access from the car park through automatic doors, wide internal doors and spacious rooms for wheelchair users and the provision of a hearing aid loop for those wearing aids.

Learning from complaints and concerns

- The centre received nine complaints between April 2015 and March 2016. There were no complaints referred to the Independent Sector Complaints Adjudication Service (ISACS), the Parliamentary and Health Services Ombudsman or to the CQC. The assessed rate of complaints is lower than other independent acute hospitals for which we hold this data.

Good

Surgery

- The centre had clear processes for dealing with complaints, including an up to date policy.
- The quality and standards manager recorded all complaints on an electronic reporting system. Complaints were logged and tracked to ensure they were responded to in accordance with the policy. A 2015-2016 complaints audit by the North Kent CCG which we reviewed found no significant areas of concern in relation to complaints, although communications issues were the dominant theme.
- Managers told us all patient feedback was welcome throughout the patient pathway. If a patient expressed concern, they were normally approached by a head of department, the clinical governance manager or head of nursing to discuss and resolve the problem before the patient complained formally. A number of options were made available to patients and visitors, including a verbal complaint form, electronic feedback devices or patient feedback forms, a 'How to make a complaint' leaflet. Patient advice and liaison literature was available in all public areas and on the NHS choices website.
- Learning was shared throughout the multi-disciplinary team through various departmental, Head of Department, Infection Control & Health and Safety (where appropriate), Senior and Governance Managers meetings. We saw evidence of minutes showing complaints were on the agenda and discussed at governance meetings. These minutes were shared with staff by email.

Are surgery services well-led?

Good

We rated the service good for well-led because:

- There was a clear governance structure in place utilising multidisciplinary committees working closely with the senior management team (SMT). Issues affecting safety and quality of patient care were known, disseminated, managed and monitored.
- There was clear and highly visible leadership provided by senior management and within the departments. Staff spoke positively of their managers, who told us they were visible and approachable, and visited departments daily.
- There were high levels of staff satisfaction across all staff groups. Staff told us they felt 'proud' to work at the hospital, and there was a good team spirit and atmosphere.
- The centre actively promoted community engagement through the patient forum, a volunteer helper programme and other initiatives such as hosting clinical services and regional NHS safeguarding meetings.

Vision and strategy for this this core service

- Staff spoke highly of the service they provided and were proud of the facilities at the centre and the care they could offer to patients. They had a good knowledge of the vision and values of the organisation.
- We saw a team 'charter', which was displayed in the boardroom. This had been developed locally and were signed by all staff, which helped to reinforce their personal commitment to the values statement.

Governance, risk management and quality measurement for this core service

- The centre was led by a centre director and operations manager, who had operational responsibility for the facility. The Medical Director and the Head of Nursing had operational and professional responsibility for all clinical departments and together with finance and human resources managers formed the senior management team (SMT) for the centre. The Medical Director worked full time but shared his week between WATC and the North East London Treatment Centre (NELTC). He was managed by the Care UK Medical Director and was supported in his work by eight Clinical Directors who were responsible for the various medical specialities such as radiology, anaesthetics and orthopaedics across the group. The Medical Director retained clinical oversight of all activities at the centre as well as providing specialist input into governance issues such as the way the organisation responded to incidents and complaints.
- The SMT met monthly and we saw the minutes of the last two meetings. The minutes showed items discussed included complaints and incidents, patient feedback

and key departmental activities. Agendas and minutes showed audits and learning from complaints, learning from risk management, infection and prevention control issues, good practice, and clinical audits were discussed and action taken where required

- The centre had a nominated daily clinical lead and a member of the senior management team on site during business hours. We confirmed this when we arrived for our unannounced visit.
- The provider monitored the quality and safety of the service. The centre produced a monthly dashboard of a range of KPI's set by Care UK including indicators around patient safety, quality, infection prevention and control, patient satisfaction and business and financial performance. Performance was benchmarked against peers and we saw the centre was performing at around the mid-point for the majority of indicators.
- Key performance indicators were reviewed monthly and lessons learnt were fed back at quality governance and department meetings. Learning from incidents and root cause analyses (RCA's) were shared with the staff and improvement plans initiated.
- Staff had access to intranet-based information on new guidance and anything relevant to the centre was circulated via email or meetings.
- Visits from corporate senior managers were reported, such as the Care UK director of nursing, governance director and deputy director for infection prevention and control, to provide support, complete audits and meet with the teams.
- The centre had an electronic risk register and associated risk assessments were accessible here. We saw evidence of entries related to the outpatients department on the centre risk register. Departmental risk registers were also located on the shared drive.
- We noted a number or corporate polices and service level agreements (SLA) were past their review dates, or had not been reviewed for a considerable length of time. We looked at 15 corporate policies at random on line and noted three (20%) were no longer current, although none these were clinical policies. We saw two SLA's that did not have review dates recorded. This meant there was a risk that policies may not reflect current best business practice.

Leadership / culture of service related to this core service

- All staff we spoke with were positive about their relationships with their immediate managers. Staff felt they could be open with colleagues and managers and felt they could raise concerns and be listened to.
- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities and they told us they saw their line managers on a daily basis. This was reflected in the most recent staff survey when 92% of respondents said they "knew what was expected of them at work" and the same figure for "I know who the senior managers are in my area".
- Staff reported good morale and felt supported. All staff told us they felt encouraged to be engaged in the provision of services and this increased their motivation. Staff visitors, such as a volunteer and a student nurse echoed these comments.
- Sickness rates for all staff were 2% in the last year. Staff turnover figures showed that while nurse staffing rates for theatre were above the average for independent acute hospitals, there was no turnover in nurses in the day-case wards. Moreover, there was no turnover of ODPs or HCAs working in either area, indicating that theatre staff felt positive about working for the organisation. The centre acted on and made improvements from staff feedback. We saw a "you said, we did" notice board outside the staff kitchen, displaying some of the changes made.
- Consultants we spoke with were positive about members at the centre and described good working relationships across all staff groups.
- We saw that staff worked well together and there was respect between specialities and across disciplines. We saw examples of strong collaborative team working on the day-case wards between staff of different disciplines and grades.
- Care UK had begun collecting data to ensure that it could meet the publication of the Workforce Race Equality Standard information that will be required in 2017. We saw the centre had an action plan related to this project although work on this was yet to begin.
- On our unannounced visit we saw the centre's management team had developed an action plan based on the initial feedback we had given and work has begun to address some of the issues raised. This showed that the leaders were receptive to feedback and responded promptly.

Public and staff engagement

- We observed patients being actively encouraged to provide feedback about their experience using the electronic patient satisfaction questionnaire and we spoke to a volunteer and a member of the patient forum who supported this.
- Patient feedback results were collated by a third party data collection company and reviewed at the quarterly quality group meeting which identified any areas for improvement and actions required. Any comments mentioning staff by name were forwarded to the individuals involved for appraisal and revalidation.

Staff had regular department meetings to offer group supervision and discuss performance issues and processes that may affect the running of the unit.

- The centre had created a ‘patient forum’ to enhance communications and the flow of information with service users locally as well as the patient experience within the centre itself. We saw examples of meeting notes from this forum showing the flow of information and level of engagement.

Innovation, improvement and sustainability

- Real time theatre monitoring was displayed to enhance the centre’s ability to provide an effective and efficient service that reduced delays and inconvenience to patients.
- We learned that the organisation had rolled out an IT based project intended to look across outpatients departments and theatres to identify efficiencies by non-clinical means. Part of the project was to assess the time individual clinicians required for each procedure to ensure the maximisation of theatre time, and to minimise delays for patients. We saw that there was information displayed around the centre to keep staff updated with the progress of this project.

Good

Outpatients and diagnostic imaging

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

Information about the service

Start here...

Outpatient services at Care UK Will Adams NHS Treatment Centre cover specialities including anaesthetics, gastroenterology, orthopaedics, general surgery, ophthalmology and urology. From April 2015 to March 2016, the outpatient department provided 4,164 new patient appointments and 4,197 follow up appointments, all for NHS patients. The centre told us that they did not see children in outpatients and no children attended the outpatient department between April 2015 and March 2016.

There are seven consulting rooms; five consultant led and two nurse led pre-assessment rooms.

The centre is open 7:30am to 7pm Monday to Saturday. On Tuesday evening sessions run until 9:30pm. The outpatient department runs clinics approximately one Saturday a month based on demand.

The centre has no diagnostic imaging facilities on site, all of these services provided are outsourced through service level agreements with external providers.

There is no onsite pharmacy. A weekly pharmacy service is provided by a registered pharmacist from the sister centre at Care UK North East London Treatment Centre and a courier delivers drugs.

During our inspection, we spoke with eight members of staff including nurses, administrative staff and senior managers. We spoke with five patients. We also reviewed six comment cards with feedback from patients. We reviewed six sets of patient records and we looked at policies and procedures, staff training records, audits and the environment and equipment.

Outpatients and diagnostic imaging

Good

Summary of findings

Start here...

We found the outpatient services at Will Adams NHS Treatment centre to be good because:

- There were appropriate systems in place to keep patients safe.
- Staff were aware of the incident reporting process and shared learning locally.
- We saw the outpatient areas were clean and that equipment was well maintained.
- Staffing levels were appropriate, without the need for agency staff.
- Patient records were routinely available for outpatient appointments.
- The centre had an on-going audit programme, which monitored areas for improvement regularly.
- We observed staff were caring and treated patients with kindness. Patients told us they felt listened to.
- There was an interpreter service available for patients whose first language was not English.
- Appointments could be accessed in a timely manner and at a variety of times throughout the day.

Are outpatients and diagnostic imaging services safe?

Good

We rated safety as good for the outpatient service. This was because:

- Staff had an understanding of the incident reporting process and the duty of candour. Incidents were discussed regularly at governance meetings and feedback of learning from incidents was cascaded to all staff.
- Good infection control practices were in place and demonstrated and were in line with national guidance.
- Equipment was tested and serviced regularly.
- We saw medicines were stored securely and there was appropriate monitoring and storage of prescription pads.
- Records were complete, legible and stored accurately. There was an effective process for tracking records in place. Records were routinely available when a patient attended for an outpatient appointment
- Overall compliance with mandatory training was above the services target, staff reported they had the time to complete this and were sent reminders when training was outstanding.
- Staff were able to outline the procedure in the event of a patient becoming medically unwell and the centre performed quarterly role-play scenarios to audit this.

However:

- Document control related to medicines management was not satisfactory, the CARE UK medicines management policy was out of date and we saw out of date protocols and Patient Group Directions (PGDs) being used for reference.

Incidents

- There were no never events reported by the centre between April 2015 and March 2016. ‘Never events’ are serious, largely preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.
- Out of 95 clinical incidents reported at the centre between April 2015 and March 2016, four occurred in

outpatient department. This is below average compared to other independent acute hospitals CQC hold this type of data for. There were no non-clinical incidents reported within the department for this reporting period.

- An up-to-date Care UK policy related to incident reporting was in place.
- Staff had an awareness of the electronic incident reporting system and were able to give us examples of what they would report, although few had recently reported an incident. They told us this was because there had been nothing to report. Most staff told us they would also verbally inform their line manager of the incident.
- Staff told us that learning and feedback from incidents was discussed at staff meetings and quarterly governance meetings and we saw minutes of these meetings which indicated that this was occurring regularly. These minutes were shared by email for those staff unable to attend the meeting.
- The duty of candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient's safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. Most staff had an awareness of the duty of candour but had not had to demonstrate it. Ninety per cent of centre staff had completed mandatory training regarding the duty of candour, which met the centre's target.

Cleanliness, infection control and hygiene

- Up-to-date Care UK policies and best practice guidelines were in place for infection control and hand hygiene respectively. At the centre, 96% of staff had completed infection control mandatory training, which was above the centre's target of 95%.
- All the areas we visited in the outpatients department were visibly clean and tidy and there were good infection control practices in place
- The patient-led assessments of the care environment (PLACE) score completed in 2015 scored 99% for cleanliness, which was better than the national average of 98%. Staff were bare below the elbow and there was information displayed demonstrating the World Health Organisation (WHO) guidelines on hand hygiene in healthcare near handwashing sinks. The centre performed quarterly hand hygiene audits and the audit completed in February 2016 had scored 100%.
- There were sufficient numbers of handwashing sinks available. Lever operated taps were in place and liquid soap dispensers and paper hand-towel dispensers were conveniently placed by all wash-hand basins. This was in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Antimicrobial hand-rub dispensers were readily available in all areas including the reception desk where patients booked in for their appointment.
- We saw personal protective equipment was available for staff to use.
- We saw disposable curtains used in clinic rooms, dates on them indicated they had been changed within the last month which indicated they were changed routinely as per HBN 00-09 Infection control in the built environment, 3.139
- We observed flooring in clinical areas complied with the HBN 00-09: Infection control in the built environment, 3.109.
- Clinic rooms had colour coded waste bins for the segregation of clinical and general waste which were being used appropriately. This was in line with Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health and health and safety at work regulations.
- We saw sharps bins were available in treatment areas which were being used appropriately in compliance with health and safety regulations 2013 (The sharps regulations), 5 (1) d, which requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area.

Environment and equipment

- The outpatient department had seven consulting rooms and a waiting area within the main centre reception area. We saw tidy and spacious waiting areas with adequate seating available and consulting rooms were visibly clean and uncluttered.
- Consulting rooms had equipment to provide physical measurements. This was in line with the HBN 12 (4.18) which recommends a space for physical measurements be provided so this can be done in privacy.

Good

Outpatients and diagnostic imaging

- Equipment was visibly clean; however there was no indication on the equipment to indicate when it had last been cleaned.
- Equipment was tested and maintained through maintenance contracts and we reviewed two maintenance contracts for medical devices, one was in date and the other was currently being reviewed. We saw stickers on equipment, which indicated it had been serviced recently. Electrical equipment had stickers on which indicate it had undergone electrical testing and was safe to use. All equipment had a sticker to indicate the asset number.
- The PLACE score for in 2015 scored 98% for condition, appearance and maintenance, which was better than the national average of 92%.
- An assessment by an external organisation in April 2016 showed the centre complied with requirements for International Organisation for Standardisation (ISO) 14001 certification; this indicated there were appropriate environmental management systems in place. The ISO international standards set out the criteria for an environmental management system.
- We saw evidence of staff completing competency assessments related to use of equipment.

Medicines

- The Care UK Health Care Medicines Management Policy was due for review in April 2015 which meant staff were following guidance which had not been recently reviewed
- The centre had a local medicines formulary, which staff could access via the centre website; this complied with National Institute of Health and Care Excellence (NICE) guidance (MPG1): developing and updating local formularies.
- As there was no pharmacy department on site, a standard operating procedure (SOP) for collection and delivery of medicines was in place. Staff working in the outpatient department were able to describe the process for ordering medicines from the centre in North East London as per the SOP.
- The outpatient department had one locked medicine cupboard containing eye drops. This was in a locked, temperature-controlled room. Keys to the medicines cupboard were in the possession of the registered nurse at the time of the inspection. The department did not use controlled drugs and medication-requiring refrigeration was stored in the ward fridge.
- Prescription pads were stored in a locked cupboard, within a lockable room. Staff told us the room was locked when not in use and keys kept with a designated member of staff within the department We saw a log which indicated when a prescription had been issued, to whom and what for. Two nurses signed each entry and there was evidence of monthly checks on the number of prescriptions. This is in line with NHS Protect, security of prescription forms guidance 2013. However, the folder containing the logs also contained a copy of the protocol for issuing prescriptions for reference, which was due for review in February 2011.
- Out-of-date copies of the September 2013 to March 2014 British National Formulary (BNF) were available in hard copy throughout the outpatients department, which meant patients could be treated based on outdated information. These were disposed of when we raised this.
- A Patient Group Directive (PGD) provides a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor. A PGD is used in situations that offer an advantage to patient care, without compromising patient safety. There were PGDs for eye drops that nursing staff gave to patients without a formal prescription. However, we saw three PGDs during the inspection; all of these were due for review in 2009 or 2011. There was no record of staff deemed competent to supply or administer medication under the PGD's. The centre later provided us with an updated copy of one of these and an additional PGD, both of these were due for review in October 2017, and had signed sheets of individuals authorised to administer against each one. This demonstrated a risk that outdated information was being used to treat patients as a result of poor document control.
- At the centre, 83% of staff had completed medicines management mandatory training, which was worse than the centre's target of 90%.

Records

- Staff told us that at the point of receiving a referral for a patient there was a minimum data set requirement, which must be met in order for the patient to proceed. Once the patient was clinically triaged and accepted, a Care UK medical record was created and the notes were available in clinic on the day of the patient's

appointment. We observed that all patients seen in outpatients had a full medical record available. Staff told us there was never a time when a patient was seen in clinic without relevant records being available.

- We observed the medical records being stored securely in a locked cupboard at reception on the day of the patient's clinic appointment. Staff told us that these were then stored in the medical records department on site and archived three months after the patients' last episode of care at the centre.
- The centre had an electronic tracking system for patient records. We observed it in use by administrative staff and they told us it was robust and easy to use to trace the location of patient records.
- We reviewed six sets of patient records. We saw records were complete, legible, signed and dated. They contained peri-operative pathway documentation, evidence of post-operative phone call, referral letters and discharge letters.

Safeguarding

- Up-to-date Care UK policies for safeguarding adults and safeguarding children were in place.
- There had been no safeguarding concerns reported to CQC in the reporting period from April 2015 to March 2016.
- In the centre, 91% of staff had completed level one safeguarding vulnerable adults training and 88% had completed level two training. The centre's safeguarding lead was trained to level four, which was higher than the minimum level three training as per the Care UK safeguarding policy. All staff we spoke to were aware of who the safeguarding lead was and demonstrate what they would do if they had a concern.
- In the centre, 86% of staff had completed level two safeguarding children training, which was below the centre target of 90%. The requirement for staff to attend level two training was in line with the Safeguarding Children and Young People – Roles and Competencies for Staff intercollegiate document, 2014 as the centre did not treat children.
- Ninety-three per cent of centre staff had attended prevent training. Prevent is part of the government counter-terrorism strategy. It is designed to tackle the problem of terrorism at its roots, preventing people from supporting terrorism or becoming terrorists themselves. Centre management told us that a member of the senior management team had completed Workshops to Raise Awareness of Prevent (WRAP) training and would provide prevent training to new staff in future following a trainer's course. Until such time face-to-face training would be supported by a member of staff from another Care UK treatment centre.

Mandatory training

- Staff completed a number of mandatory training modules mainly via e-learning packages, with some practical sessions such as manual handling. Across the centre, overall compliance with mandatory training was at 95%, which was above the centre's target of 90%. There was no breakdown of data provided to demonstrate compliance with mandatory training for the different outpatient areas or specific staff groups.
- Staff told us mandatory training was easy to access, was completed during working hours and staff received an email reminder if they had any training outstanding.

Assessing and responding to patient risk

- We saw the centre's policy for managing referrals. The policy included the exclusion criteria as set out in the centre's NHS contract. A detailed list is also published on the centre website as information for referrers.
- We saw the checklist for patients attending pre-assessment clinic which included carrying out a venous thromboembolism (VTE) risk assessment. Both staff and patients' signed the checklist to acknowledge that information had been given and received.
- The centre completed quarterly emergency scenario role-plays such as collapse and anaphylaxis, audit records in December 2015 and March 2016 showed 100% compliance.
- An anaesthetist was always on site when patients were present to provide senior medical cover. This provided support to the outpatient's staff if a patient became unwell
- A protocol for the management of a deteriorating patient was in place, staff understood the process and we saw a copy of the protocol displayed.
- Patients were given an out of hour's phone number to call in case of an emergency when the centre was closed which provided reassurance to the patients.

Staffing

- A registered nurse was available in the outpatients department during opening times. The department

employed three full time equivalent registered nurses and 1.9 full time equivalent health care assistants (HCAs). The outpatients department had a ratio of nurse to health care assistant of 1 to 0.62.

- The outpatient department had not used use any bank or agency staff from April 2015 to March 2016 as staffing was sufficient.
- Staff working in the outpatient department told us they also worked on the ward as support when there were gaps between clinic lists.
- There were no set guidelines on safe staffing levels for outpatient clinics. Staffing levels were determined by the department manager based on expected workload for each clinic list.

Major incident awareness and training

- An up-to-date Care UK incident management and escalation procedure was in place. Additionally there was a local business continuity plan, a fire evacuation plan, and a severe weather plan which were also in date. A copy of the policies in addition to other relevant items such as high visibility jackets, action cards and anaesthetics rota were stored in an emergency/incident action box at reception, which would be the coordination point in the event of an incident.
- The centre had ingress of water in January 2016, which tested the service's business continuity plan. Staff told us it worked well resulting in minimal disruption to outpatient appointments. We saw updates to the policy reflected the centre had actioned learning from the incident.
- We saw records, which showed the centre performed biannual fire drills and weekly alarm tests. The fire warden for the day was clearly identified in the reception area. A fire risk assessment had been completed in July 2016 and the management team could discuss the recommendations that had been made and demonstrated that they were considering the actions required.

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. Overall, we found:

- The centre had an ongoing audit programme, which monitored areas for improvement regularly.
- Treatments offered to patients were in line with National Institute for Health and Care Excellence (NICE) guidelines.
- Staff were competent to perform their roles and opportunities were available to develop their roles further.
- The centre invested in a range of high quality, endorsed patient information leaflets.

However:

- Competency assessment documents were passed their review dates.

Evidence-based care and treatment

- The centre has an ongoing audit programme. Regular audits included infection control, hand hygiene and Central Alert System (CAS) and National Institute of Health and Care Excellence (NICE) Guidance audit. We saw copies and results of the May 2016 audit which showed 100% compliance.
- We looked at a range of Care UK policies and saw they referenced relevant national guidance such as that from NICE or the Royal Colleges and other learned societies.
- Staff in the outpatient areas reported they followed national or local guidelines and standards to ensure patients receive effective and safe care. An example of this was the pre-assessment team gave information relating to keeping patients warm before, during and after general anaesthetic during the pre-operative assessment clinic in line with NICE guidance Hypothermia: prevention and management in adults having surgery.

Nutrition and Hydration

- Vending machines and water dispensers were available in the outpatient waiting areas. This meant patients and relative had access to snacks and drinks whilst they waited.
- Staff told us patient's would be offered a drink if they were on site for over two hours. We spoke to patients who told us they had been offered drinks. As the centre did not have overnight patients there were no catering facilities on site and therefore patients could not be offered food.

Pain relief

- At the time of the inspection, we did not observe any patients who required pain relief. The outpatient department did not stock a supply of oral pain relieving medication but staff told us these could be prescribed on an outpatient prescription, which the patient could take to their local pharmacy.
- The use of local anaesthetic during procedures enabled patients to return home the same day. We saw patient group directions (PGDs) in place, which allowed nurses to administer topical anaesthetic eye drops for assessment of patients postoperatively following cataract surgery this meant that patients had adequate pain relief.

Competent staff

- In the outpatient department, 100% of nurses and health care assistants (HCAs) had an appraisal in the last year. Staff told us they felt the appraisals were valuable and included discussions regarding further training opportunities and compliance with requirements for continuous professional development.
- Staff had opportunities to develop professionally. An HCA gave us an example that she had on the job training over a two-year period to allow her to complete eye biometry readings; however, there was no formal sign off process. Eye biometry is a test to measure the shape and size of the eye. It is commonly used to calculate the power of intraocular lens implants required for cataract and refractive surgery.
- We saw a monthly Care UK spreadsheet, which outlined the current registration of staff with the General Medical Council (GMC), Health Care Professions Council (HCPC) and Nursing and Midwifery Council (NMC) as appropriate. We noted that all registrations were up to date. The centre also maintained a local spreadsheet of registration renewal dates for HCPC staff and registration renewal and revalidation dates for NMC registered staff.
- We reviewed two doctors employment files, these contained evidence of revalidation and insurance and appraisals if employed over a year. We saw a clinical services agreement between Care UK and the Consultant Eye Surgeons Partnership (CESP), which requires CESP to keep essential evidence such as Disclosure and Barring Service (DBS) checks and health clearance.
- We reviewed five employment files of nursing and administrative staff, which contained evidence to indicate files were up to date, and contained relevant information such as evidence of DBS checks, health clearance and necessary qualifications.
- The service used specialist nurses in clinics, these included ophthalmology and pre-operative assessment clinics. This meant patients received care from appropriately trained and qualified staff.
- We saw completed and signed competency assessments and competency certificates for a variety of areas such as; registered nurse pre-assessment and outpatient competencies, ophthalmic nursing competencies and equipment competencies to be completed by all staff. However, all the competency assessment documents were past their review dates and the centre could not provide us with a list of staff that had completed each competency assessment this meant there was a lack of assurance regarding staff competence. We saw minutes of a secondary care professional heads meeting which showed the centre was working towards an online platform to display competencies.

Multidisciplinary working (related to this core service)

- We observed a one-stop ophthalmology clinic in progress. Patients saw a health care assistant for biometry before seeing the ophthalmology specialist nurse. Ophthalmology is the branch of medicine concerned with the study and treatment of disorders and diseases of the eye.
- From the care we observed, there was effective team working, with strong working relationships between all staff groups.

Seven-day services

Good

Outpatients and diagnostic imaging

- Clinics in outpatients were held from Monday to Friday and one Saturday a month, with early morning and late evening appointments available. This meant patients had a choice of days and times for their appointment.

Access to information

- We saw the centre's policy for managing referrals. The schedulers were able to describe the process of managing referrals from GPs and obtaining the minimum data set of information regarding the patient as per the policy. This meant staff had access to relevant information when a patient was seen in clinic.
- Staff told us patient notes were routinely available when a patient attended an outpatient appointment to ensure continuity of care.
- We saw copies of clinic letters and discharge information was sent to the GP and filed in the patient notes to ensure continuity of patient care.
- **Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)**

- In the centre, 94% of staff had completed MCA and DoLS training; above the trust target of 90%.
- An up to date Care UK Assessing Capacity and Deprivation of Liberty Safeguards policy was in place. The centre had Care UK best interest decision record forms and consent forms specific to patients who lacked capacity to make decisions or were unable to give consent available in pre-assessment rooms.
- The Care UK Consent for Physical Examination and Treatment Policy was out of date.
- Patients attending clinic for pre-operative assessment were given a copy of the consent form. This showed the patients were encouraged to consider all information available to them and to consider their consent.
- Support was available for patients to enable informed decisions, about their treatment, prior to giving consent. Information leaflets given to patients included the risks and benefits of the proposed procedure or surgery. Care UK patient information leaflets stated that nothing would happen until the patient fully understood and agreed with what the plan and the patients' right to refuse or delay treatment.

Are outpatients and diagnostic imaging services caring?

We rated caring as good for the outpatient service. This was because:

- Patients told us they were happy with the care they received.
- Staff treated patients with kindness, providing reassurance and support.

However:

- Posters relating to the chaperone policy did not highlight the choice for the patient to request a member of staff as a formal chaperone.

Compassionate care

- The most recent NHS Friends and Family test (FFT) data provided to us was June and July 2016, which indicated 99% or more patients would recommend the outpatient department at the centre. However, the response rate was low at 45% and 28% respectively.
- Patients told us staff were friendly and reassuring, and they would be happy to recommend the centre to friends and family. We observed staff interacting with patients with kindness in a calm and relaxed way
- We saw feedback from the centre's patient experience questionnaire displayed in the reception area. The centre provided us with patient satisfaction comments from the May 2016 survey, these were mostly positive however, three patients commented on the waiting time at the centre before their appointment being too long.
- We reviewed eight feedback cards that had been completed by patients visiting the outpatient department. Consistent comments on the feedback cards were the warmth and friendliness of the staff, cleanliness of the department and patients' felt they were listened to.
- In the outpatient waiting area there was a folder containing over 100 thank you cards received from patients dated from July 2012 to July 2016. This showed the centre provided consistently good care to patients.
- The centre PLACE audit score in 2015 for privacy, dignity and wellbeing scored 89%, which was better than the national average of 87%.

Outpatients and diagnostic imaging

Good

- We observed all clinical activity was provided in individual consulting rooms with the doors closed, to maintain privacy and confidentiality.
- An up to date Care UK chaperone policy was in place. We saw poster titled "Privacy and Dignity" in the reception area, these informed patients that relatives could accompany them where possible but this may sometimes not be possible in order to protect the privacy of other patients. They did not, however, make clear the patient's choice to have a member of staff as a formal chaperone.

Understanding and involvement of patients and those close to them

- Patients we spoke to told us that they felt staff gave them appropriate information. This was also reflected in comments from the May 2016 patient satisfaction survey.
- We observed staff giving patients appropriate information when they were booking follow-up appointments, staff also informed patients that an appointment letter with detailed information about the appointment would also follow.
- We saw documentation in patient records about discussions at pre-assessment clinic. This included details of appropriate information given to patients.

Emotional support

- Patients told us that staff were understanding and they felt listened to. One patient told us that a nurse held her hand through her assessment, which was reassuring, and she was offered a cup of tea afterwards.
- Comments in the May 2016 patient satisfaction survey indicated that staff were reassuring and made patients feels safe.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsiveness as good for the outpatient department. This was because:

- The service offered a variety of appointment times to suit the needs of the patients.
- Patients could book their next appointment date or if appropriate, an admission date for surgery on the day of their outpatient appointment.
- Staff were aware of how to access interpreters.
- Staff at the centre were aware of the centre's dementia strategy and followed this.

However:

- Patient information leaflets were not available in other languages.

Service planning and delivery to meet the needs of local people

- Clinics in outpatients were held from Monday to Friday and one Saturday a month, with early morning and late evening appointments available. This meant patients had a choice of days and times for their appointment.
- The centre was working with the local Clinical Commissioning Group (CCG) to give local people a choice of where they received treatment.

Access and flow

- Referral to treatment (RTT) waiting times for non-admitted patients beginning treatment within 18 weeks of referral were above 95% in each month of the reporting period April 2015 to March 2016, this was better than the standard. However, there was no data for July 2015.
- Clinic waiting times for the centre are available on the website. Waiting times at the time of inspection ranged from two to seven weeks. There was a note on the website stating the waiting times were indicative and could change on a daily basis.
- The patient schedulers used robust electronic systems to manage the scheduling of clinics and also maintained a back-up spreadsheet. Patients could book their appointments using the NHS e-referral system or through the centre directly over the phone or in person allowing them a choice of the date and time of their appointment. We saw a receptionist tell a patient that she would also receive a letter confirming the date and time of her appointment in the post.
- We observed a patient booking an appointment for her procedure at reception following her clinic appointment with a specialist nurse. She requested to see a specific consultant, the scheduler proceeded to book the appointment but as the consultant was on leave the

patient decided to see an alternative consultant so she could be seen sooner and the receptionist was able to book her an alternative appointment. This meant the patient left with an appointment day for her procedure.

- Staff told us the centre had an electronic system that monitored clinic start times, waiting times and Did Not Attends (DNAs) although they told us this was not an issue. They told us patients would be told verbally if a clinic was running late and it would be written on the whiteboard in the reception area. Three patients commented on the delays due to late running clinics in the May 2016 patient satisfaction survey.

Meeting people's individual needs

- Patient areas of the centre were all on the same floor therefore all areas were accessible to wheelchair users.
- The centre had an up to date dementia strategy for the current year. It pledged to assess all patients over the age of 75 for dementia at pre-assessment and refer any patients newly identified with dementia or memory loss to their GP. Staff told us this was completed routinely and we saw assessment forms available in the consulting rooms.
- Staff told us 'helping hands' stickers were placed in patients' notes to indicate a patient needed more assistance and we saw these used in patient records we reviewed. This was in line with the centre's dementia strategy.
- Staff told us interpreters could be booked if needed by patients and they had a clear understanding of how to do this. The centre did not allow relatives to translate for patients in line with best practice. However, staff told us the patient information leaflets were not available in other languages.
- A range of high quality, patient information leaflets, endorsed by relevant Royal Colleges and learned organisations were available.

Learning from complaints and concerns

- The number of complaints received from the centre from April 2015 to March 2016 was nine, which was a decrease from April 2014 to March 2015, when they received 16. No complaints had been referred to the Ombudsman. The assessed rate of complaints (per 100-day case and inpatient attendances) was lower than other independent acute hospitals the CQC hold this type of data for and CQC received no complaints regarding the centre from April 2015 to March 2016.
- An up to date Care UK, Compliments, Concerns and Complaints Policy was in place.
- A 2015-2016 complaints audit by the North Kent Clinical Commissioning Group which we reviewed found no significant areas of concern in relation to complaints.
- We saw evidence of minutes showing complaints were on the agenda and discussed at governance meetings. These minutes were shared with to staff by email.
- Staff told us that if complaints or concerns were verbalised by the patient whilst in the centre, the most common approach was for the patient to meet with a senior manager to discuss concerns raised and seek appropriate solutions. This was to resolve and manage concerns before the issue becomes a formal letter of concern.
- We saw 'How to make a complaint' leaflet, leaflets containing Patient Advice and Liaison (PALS) details and a 'Have your say' card asking patients to leave a review on the NHS choices website available in the outpatient waiting area. This meant the centre was actively engaging patients to obtain feedback.
- We reviewed six complaints although not all related to the outpatients' department. All of these were acknowledged in a timely manner and five of these were sent a formal response letter within 20 days as per the Care UK policy. One complaint required a root cause analysis investigation, which was in progress and there was evidence that the complainant had been advised of the progress in phone calls. However, not all responses advised the patient how to escalate the complaint if they were not satisfied with the response and there were no formal risk assessment of the complaints.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good for the outpatient service. This was because:

- Staff were proud of the service they provided at the centre and were aware of the vision and values of the organisation.
- There was a clear leadership structure and staff told us managers were visible and approachable.

- There was evidence of active staff and patient engagement.

However:

- Departmental managers lacked clarity and awareness regarding the existence of departmental risk registers and location of the departmental risk register.

Vision and strategy for this this core service

- Staff spoke highly of the service they provided and were proud of the facilities at the centre and the care they could offer to patients.
- Staff had signed a team charter, which was displayed in the boardroom, this has been developed locally.
- Staff had a good knowledge of the vision and values of the organisation.

Governance, risk management and quality measurement for this core service

- The centre's governance was managed by the Senior management Team (SMT). This included a centre director and operations manager, who had operational responsibility for the facility and a Medical Director and the Head of Nursing had operational and professional responsibility for all clinical departments. The Medical Director worked full time but shared his week between WATC and the North East London Treatment Centre (NELTC). He was supported in his work by eight Clinical Directors who were responsible for the various medical specialities such as radiology, anaesthetics and orthopaedics across the group. The Medical Director retained clinical oversight of all activities at the centre as well as providing specialist input into governance issues such as the way the organisation responded to incidents and complaints.
- The SMT met monthly and we saw the minutes of the last two meetings. The minutes showed items discussed included complaints and incidents, patient feedback and key departmental activities. Agendas and minutes demonstrated audits and learning from complaints, learning from risk management, infection and prevention control issues, good practice, and clinical audits were discussed and action taken where required.
- The centre had an electronic risk register and associated risk assessments were accessible here. We saw evidence of entries related to the outpatients department on the centre risk register. Departmental risk registers were located on the shared drive.
- We saw minutes of quality assurance and governance meetings that covered areas of good practice and risk within the outpatients department. Minutes were disseminated to staff by email so they were aware of the risks within their own department.
- We saw a copy of the centre audit plan. Audit results and review of outcomes were discussed at the quality assurance and governance meetings.
- Departmental managers lacked clarity and awareness regarding the existence of departmental risk registers and location of the departmental risk register. This did not give us assurance that they were used and updated regularly. We saw the departmental risk registers and associated risk assessments located on the share drive.

Leadership / culture of service

- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities in the outpatient department. Nursing staff in outpatients reported to the ward manager, who reported to the head of nursing, who reported to the centre director.
- Staff told us they saw their line managers regularly and told us they would feel comfortable raising concerns to them. Staff were positive about the leadership at senior management level. They told us the leadership team were visible and approachable.
- We looked at staff sickness and vacancy rates as this can be an indicator of the culture within the centre. We found staff turnover rates for nurses' working in the outpatient department was above the average when compared to independent acute hospitals, in the reporting period from April 2015 to March 2016. However, staff told us the centre was a good place to work and they felt well supported and valued for the work they did.

Public and staff engagement

- Staff regularly asked outpatients to complete satisfaction surveys on the quality of care and service they received. Results of the survey and suggested areas of improvement were displayed in the reception area.

Good

Outpatients and diagnostic imaging

- The centre had an active patient forum, chaired by the quality and standards director and supported by the chief nurse. We spoke to one of the four patient volunteers on the panel. He told us other staff also attended the forum; these have included the centre director and administrative staff. The patient volunteers were involved in completing PLACE assessments and issues such as patient privacy, new guidance, treating patients of different ethnic and religious groups had been discussed at previous meetings. Observations regarding old signs outside the centre had been actioned and the signs replaced.
- The centre participated in local events such as the Kent County Show to raise awareness of the centre and the services it provides for both public engagement and recruitment.
- We saw a poster about the colleague recognition scheme, whereby staff could nominate colleagues and this was awarded monthly. Staff told us there was also an annual Healthcare Heroes recognition scheme.
- We saw minutes of quality assurance and governance meetings. Minutes were disseminated to staff by email so they were kept updated.
- We saw a variety of appropriate general and condition specific health-education leaflets and signposting information such as Age UK leaflets and flu advice in the outpatient waiting area

Innovation, improvement and sustainability

- Staff told us that the centre had an electronic system that monitored clinic start times, waiting times and Did Not Attends.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The provider should**:**

- Improve document control related to medicines management protocols and patient group directions (PGDs) to ensure that staff are referring to up to date versions.
- Display posters relating to the chaperone policy to highlight the choice for the patient to request a member of staff as a formal chaperone.
- Make arrangements to make patient information leaflets are available in other languages
- Ensure departmental managers are clear and aware of the location of the departmental risk registers and risk assessments.