Devizes NHS Treatment Centre

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Devizes NHS Treatment Centre is an independent treatment centre and part of Care UK Limited. At the time of our inspection it provided care and treatment to NHS patients, with no privately funded work undertaken.

The treatment centre provided surgery and outpatient and diagnostic services. The majority of services were provided to persons 18 years and over but also provided dental surgical services to persons aged between 16 and 17 years. Day case and inpatient surgery specialities included Ophthalmology, Oral surgery, ear, nose and throat (ENT), General surgery, Orthopaedic (minor), Gynaecology, and Urology. There were four pre-operative/day case admission chairs separated by partitions with a single sex changing room and toilet. There were five recovery beds and three recovery chairs. There were two operating theatres and a dedicated Endoscopy suite, which had its own self-contained Endoscope washer disinfector for decontamination. Endoscopic services included upper and lower gastrointestinal, rectal bleeding and cystoscopies

The outpatient department provided a service for patients before and after surgery. The radiology services included x-ray and ultrasound, and dental imaging. Outpatient specialties included ophthalmology, oral surgery, ear, nose and throat, general surgery, orthopaedic (major and minor), gynaecology, and urology.

A number of services were provided to the treatment centre by another Care UK facility including decontamination of instruments, pharmacy and in-patient surgery. Other services were outsourced to other providers including pathology, MRI/CT scanning, audiology, hard and soft facilities management and musculoskeletal physiotherapy.

All treatment was consultant led. Consultants were employed on either a substantive, bank or self-employed contracts. The senior leadership team included the treatment centre director, the medical director, the head of nursing and clinical services, operations manager and finance manager.

We carried out a comprehensive announced inspection of Devizes NHS Treatment Centre on 13 and 14 September 2016 and an unannounced inspection on 21 September 2016. We inspected and reported on two core services, the surgical services and the outpatient and diagnostic imaging service.

The overall rating for the Devizes NHS Treatment Centre was good. We rated both core services as being good for safe, caring, responsive and well led. We rated surgical services as good for effective but did not rate outpatient and diagnostic imaging for this domain. Our key findings were as follows:

Are services safe?

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

We rated safety overall as good because:

- The provider promoted a culture of openness and transparency. Staff understood and fulfilled their responsibilities to report incidents with learning and trends monitored and escalated through the governance system. Staff were aware of their responsibilities under the duty of candour.
- Staff ensured that the surgical and outpatient environment/equipment were kept clean. Procedures were in place to prevent the spread of infection. Infection control was regularly audited. All equipment at the centre was regularly serviced and prompt action was taken to rectify faulty equipment.
- The electronic patient record system in use at the centre allowed easy but secure access for all staff. Records contained all relevant information and comprehensive assessments of patient risk, which were clear and complete. Patients were followed up by telephone after their outpatient appointment and prior to their surgery.
- There were safe systems for the management of medicines. These were monitored closely by the pharmacy team and discrepancies were fed into the governance processes.

Summary of findings

- Staffing at the centre was determined using a safe staffing tool which ensured adequate nursing and medical staff were in place when services were delivered.
- There were arrangements in place to safeguard adults and children from abuse. Concerns were reported by staff and were investigated by the safeguarding lead.

However,

- We found in storage rooms, where intravenous fluids were kept, there was no record of temperatures within those rooms being recorded. This meant that there was no assurance that the intravenous fluids in the rooms were kept safe for patient use.
- The location of the scrub sink in theatres, created a risk of the spread of infection as both clean and dirty instruments were transported past the sink before and after surgery. However, this was highlighted as a risk on the surgical department risk register, the rate of infection at the centre was very low and we were provided with evidence that a risk assessment had been carried out.
- We found fire exits were not always kept clear. We saw a supplies cage obstructing a fire exit on two separate occasions.

Are services effective?

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

We rated services overall as good for effective because:

- Services at the centre provided treatment in line with national guidance and staff were aware of and followed the relevant National Institute for Health and Care Excellence (NICE) guidelines. Comprehensive policies and procedures were in place to support staff and compliance with them was monitored to ensure consistency of practice.
- Information about patient care, treatment and outcomes was collected and monitored. There was not always sufficient data to submit to national audits but local audits were undertaken. The treatment centre participated in national Patient Reported Outcome Measures (PROMS) for groin hernias and varicose veins and hip and knee arthroplasty operations. PROMS scores for groin hernias were similar to the England average but scores could not be calculated for varicose veins as there was not sufficient data. Performance of the treatment centre was benchmarked against other Care UK centres and local independent care providers.
- There were two unplanned readmissions within 28 days of discharge between April 2015 and March 2016. This was lower than average compared to other independent healthcare providers who have submitted data to the CQC.
- There were four unplanned transfers of day case patients to other treatment centres between April 2015 and March 2016. This was lower than average compared to other independent healthcare providers who have submitted data to the CQC.
- Staff followed evidence based integrated care pathways and worked together to provide coordinated care.
- Staff were trained to enable them to effectively carry out their roles with all having an up to date appraisal. Staff were encouraged and given opportunities to attend external training. The appointment process for medical staff was rigorous and assured.
- Consent to care and treatment was obtained in line with legislation and guidance. There were systems in place to ensure the consent process was thorough and patients with additional needs were supported to make decisions. Staff demonstrated understanding of the Mental Capacity Act 2005. Due to the enforcement of patient safety inclusion criteria, patients with impaired cognition were rarely treated at the treatment centre and this legislation was rarely applied.

Are services caring?

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

Summary of findings

We rated services overall as good for caring because:

- There was a patient centred culture in all departments with staff showing care, kindness and compassion to all patients. Patients complimented the treatment and care they received, commenting that staff were courteous and respectful.
- Patients were involved in the decision making process regarding their treatment and staff kept them informed at all times.
- Scores from the friends and family test demonstrated that 99 to 100% of patients were likely to recommend the services at the centre to others.
- Staff demonstrated an encouraging, supportive and sensitive approach toward patients. Staff used communication skills to provide reassurance to patients who needed emotional support.
- All patients were chaperoned for all appointments.

However;

- There were instances where private patient conversations could be heard by staff and patients within the surgery and outpatient departments.

Are services responsive?

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

We rated services overall as good because:

- The planning of services met patients' individual needs and the access and flow of outpatient appointments, admissions and discharges was well organised. Patients were given choices of locations and times for their outpatient appointments and admission. Preparation of theatre schedules were completed three months in advance to allow time for outpatients to be given a date for their surgery at their initial appointment.
- Patients' needs were considered in the planning and delivery of the service but the provider was aware further work was needed to develop dementia care. Multidisciplinary meetings could be called and were held to discuss patient requirements. Patients with additional needs, such as learning disabilities or those living with dementia were planned for and reasonable adjustments were put in place. For example, carers were encouraged to attend outpatient appointments, double appointment slots were offered and patients could be accompanied to theatre by family members or carers.
- Complaints received were responded to in a timely manner with learning used to develop future practice and improve services provided to patients.
- Patient safety acceptance criteria were used by triage nurses to ensure only patients whose needs could be safely met were accepted at the treatment centre.
- Referral to treatment times were within 12 weeks against a target of 18 weeks. From December 2015 to the date of our inspection, patients had waited no more than six weeks for their diagnostic investigation.

However;

- The percentage of patients who did not attend for their appointment was high for initial and follow-up dental appointments.
- Some aspects of the clinic environment were not well designed to meet the needs of patients with visual impairment.
- The average waiting time was 27 minutes and some patients waited longer than one hour.

Are services well led?

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

Summary of findings

We rated services overall as good because:

- The vision and objectives for the service were evident and understood by most of the staff. There was a vision to work closely with the primary care services and local acute NHS treatment centres to expand the volume of referrals and procedures performed at the centre.
- Future plans included the introduction of a frailty screening system and a frailty lead nurse, working towards accreditation with the Imaging Services Accreditation scheme and inviting consultants from local acute treatment centres to perform procedures at the centre to provide learning opportunities.
- Within the centre there were a clear governance processes in place to monitor the service provided and reliable systems for staff to identify and escalate risks. Monthly governance meetings were held and attended by heads of department and senior management. Risks were discussed, managed effectively and reviewed regularly.
- A comprehensive audit programme was followed with results reviewed at regular meetings. Actions plans were created and implemented to improve results and performance.
- Leadership at each level was seen to be visible, approachable and responsive. Staff told us they had confidence at each level and felt supported by managers and their peers
- The centre was moving towards meeting the workforce race equality standards. In order to do this an electronic database had been created to record personal details volunteered by staff regarding ethnic background.
- The staff survey demonstrated the majority of staff felt proud of the work they did. Management had taken steps to improve integration of the staff at the Devizes site and the Care UK inpatient location at Bristol as a direct response to staff survey results in 2015.
- Engagement with patients was good as there were various opportunities to provide feedback to the centre. Response rates for the friends and families test was high which allowed feedback to be reviewed by senior management with actions taken to improve services as a result.

However,

- The format of the risk register at the centre was not user friendly and included outdated risks. There were no specific risk registers for surgery, outpatient or diagnostic imaging. This meant that open department specific risks were harder to locate on the risk register.
- There were mixed results from the staff survey, regarding how staff felt about their managers effectiveness at managing change and satisfaction with immediate line management was lower than the average across Care UK locations.

Our key findings were as follows:

- Safety within the centre was of a high standard. Staff were encouraged to report incidents which were thoroughly investigated and learning was shared across the organisation.
- Responsibilities to identify and report safeguarding concerns were understood by staff and they had received appropriate training to do so.
- The treatment centre environment was clean and staff adhered to good infection control practice.
- Staff completed comprehensive risk assessments which were audited to ensure risk to patient harm was mitigated and avoided.
- Equipment was clean, well maintained and serviced.
- Records were accurate, complete and stored securely.
- Staffing within the centre was adequate and at a safe level, with all staff adequately trained.
- Multidisciplinary team meetings and work was appropriate and benefitted patients.
- Patient outcomes were monitored and data submitted demonstrated they were within expected ranges. The treatment centre submitted data to Patient Reported Outcome Measures (PROMs) and there were no inpatient deaths between April 2015 and March 2016.
- Evidence based guidelines were used to provide care and treatment to patients.

Summary of findings

- All treatment was consultant led.
- Patient feedback was consistently positive in respect of their care and treatment.
- Patients were kept informed of their care and were actively involved in the decision making process.
- The treatment provided was patient centred and all staff was caring, kind and compassionate.
- Referral targets at the centre were being met consistently.
- Patients were given a choice of suitable appointments and treatment was cancelled or delayed only when necessary.
- The service provided to patients was responsive to their needs and reasonable adjustments made for patients living with dementia or learning disabilities.
- Patient feedback was actively sought and used to make improvements.
- Clear governance arrangements were in place and risks were identified and managed.
- Service quality was monitored and reviewed through an extensive audit programme.
- Staff feedback about leadership was generally positive.
- The senior management team were visible, approachable and supportive.

However:

- There were issues with the processes and practice for identifying and escalating risks.
- Intravenous fluids were not always stored appropriately which made them potentially unsafe for patient use.
- Private patient conversations were not always confidential.
- Fire exits were not always kept clear.

We saw areas of outstanding practice including:

- Utilisation of multidisciplinary meetings was good as it gave staff the opportunity to discuss patient requirements and put reasonable adjustments in place at the earliest opportunity.

However, there were also areas of where the provider should make improvements. The provider should:

- Take and record temperatures of all rooms containing intravenous fluids, to ensure intravenous fluids are safe for patient use.
- Ensure that confidentiality is maintained at all times, specifically when patients are using admission bays and consulting rooms.
- Ensure that the procedure for unloading trolleys of supplies is reviewed in relation to the requirement to maintain access to the fire exit at all times.
- Take action to reduce the percentage of patients who did not attend for their appointment in the dental surgery clinic.
- Consider ways to make the environment of the outpatient clinic more accessible for patients with visual impairment.
- Review the functionality of the risk register so that staff are able to clearly identify the measurable controls in place to mitigate risks as well as the gaps in controls. The risk register should clearly identify which core service(s) the risk applies to and contain all significant risks.
- Ensure that regular team meetings occur at the Devizes for outpatient department and that these meetings are attended by the outpatient department manager.

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**	We rated surgery as good overall because: • Staff understood and fulfilled their responsibility to report incidents. There was shared learning from incidents, both locally and throughout Care UK. • Monitoring patient safety was a high priority and there were effective systems in place for doing so. • Treatment was provided in line with national guidance and any updates were made known to all staff. • Staff were supported by senior management and policies were in place which offered clear guidance on all relevant practice. • Staff treated patients with dignity and their thoughts, feelings and wishes were considered when treatment was provided. • Training was provided to staff which supported them to deliver care that was safe and of a high quality. • Feedback from patients about the care they received was positive. Staff were seen to be kind and caring with a focus on individualised patient care. • Patient's needs were met through the use of effective planning. The admission and discharge of patients was well organised which enhanced the patient's experience. • The provider investigated complaints and responded to them in a timely manner. Learning was shared to improve and develop practice. • Governance processes were clear and ensured quality, safety and care were monitored. Regular meetings and reporting ensured that performance and risks were understood by staff at all levels. • Leadership within the service and at each level was seen to be visible, approachable and responsible. Staff were confident in the leadership and felt able to raise concerns. However:

Summary of findings

- The risk register in operation at the centre was not always updated regularly.
- The temperatures in some of the store rooms were not recorded which posed a safety risk in terms of intravenous fluids not being safe for patient use.
- Patient's confidentiality was not always maintained when they were in admission bays being admitted for surgery

Outpatients and diagnostic imaging

Good

We rated outpatients and diagnostic imaging as good overall because:

- Incidents were reported and thoroughly investigated, and learning was shared. Trends from incidents were monitored and reviewed.
- The outpatient department environment was clean and staff adhered to infection control protocols. There had been no incidents of treatment centre acquired infections during the twelve months preceding our inspection.
- There were safe systems for the management of medicines. These were monitored closely by the pharmacy team and discrepancies were fed into the governance processes.
- There was adequate nursing and medical staff as determined by the use of a safe staffing tool.
- Individual patient care records were comprehensive, legible and complete. Records were stored securely.
- There was good compliance with mandatory training including safeguarding adults and children. Safeguarding concerns were reported by staff and were investigated by the safeguarding lead.
- Staff assessed and responded to patient risks. The patient experience nurse followed up all patients by telephone after their outpatient appointment and prior to their surgery. This nurse ensured that all investigations and screenings were completed, and checked that patients understood and were compliant with pre-surgery guidance such as changes to medication routines.
- Outpatient department teams reviewed assessment and treatment protocols in line with guidance published by the National Institute for Health and Care Excellence.

Summary of findings

- Staff in the diagnostics service followed best practice guidelines including use of local rules and diagnostic reference levels to aid optimisation in medical exposures.
- The outpatient service participated in a comprehensive audit programme and submitted patient reported outcome measures for groin hernia repair and varicose vein operations.
- All staff had an up to date appraisal. Staff were encouraged to attend external training. The appointment process for medical staff was rigorous and assured.
- There were good interdisciplinary relationships within the treatment centre. Clear referral criteria were available for referring health professionals.
- All relevant information needed for patient care was accessible to staff.
- Patients attending outpatients and diagnostics were extremely likely or likely to recommend the service to others.
- Staff showed an encouraging, supportive and sensitive approach toward patients and used communication skills to provide reassurance to patients who needed emotional support.
- Patients were given a choice of locations for their outpatient appointment. Theatre schedules were prepared three months in advance to allow outpatients a choice of date for their surgery.
- Referral to treatment times were within 12 weeks. Radiology images were reported on within 24 hours.
- Multidisciplinary meetings were held to discuss the requirements of patients with additional needs such as learning a disability. Reasonable adjustments were made such as encouraging carers to attend the outpatient appointment and booking double appointment slots.
- The registered sick children's nurse ensured that the specific requirements of patients aged 16-18 years were identified and addressed prior to their surgery date.
- Complaints were investigated thoroughly and learning was shared across teams.
- Governance systems were in place to ensure safe care for patients. There were reliable systems for staff to identify and escalate risk

Summary of findings

- In the monthly governance meeting, senior staff discussed and reviewed key performance data and updates to clinical protocols and guidelines.
- There was a comprehensive programme of audit. Actions were taken to make improvements as a result of audits.
- The treatment centre was moving towards meeting the workforce race equality standards. An electronic database had been set up to record personal details volunteered by staff regarding ethnic background.
- Staff told us they felt supported by managers and their peers
- There was good engagement with patients and with staff.

However

- Not all staff prioritised the requirement to keep fire exits clear. We saw a supplies cage obstructing a fire exit on two separate occasions.
- Staff turnover was high during April to July 2016.
- Not all staff took action to minimise risks to the privacy of patients during outpatient consultations.
- The percentage of patients who did not attend for their appointment was high for dental first appointments and for dental follow up appointments.
- Some aspects of the clinic environment were not well designed to meet the needs of patients with visual impairment.
- The 2016 staff survey identified areas for improvement.
- Details of the controls and gaps in controls on the risk register were not consistently well defined.
- The risk register was not specific to core services and contained both open and closed risks. This meant that open risks specific to the outpatient department were less easily located on the risk register.

Summary of findings

Contents

Good

Devizes NHS Treatment Centre

Services we looked at
Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Devizes NHS Treatment Centre

Background to the Devizes NHS Treatment Centre

The Devizes NHS Treatment Centre opened in November 2009. This treatment centre operated in partnership with a Care UK inpatient facility situated 30 miles away in Bristol. Both sites shared the same senior management team and heads of department. The patient pathway utilised services at both sites giving patients the option of having appointments and surgery at either one.

The Devizes NHS Treatment centre houses four standardised consulting rooms to carry out consultations for new and follow up patients equipped to perform minor procedures: naso-endoscopies, ear suctioning, biometry and 'Yag' laser and haemorrhoid banding. Outpatient specialties included ophthalmology, oral surgery, ear, nose and throat, general surgery, orthopaedic, gynaecology and urology. The radiology services included x-ray, ultrasound and dental imaging.

There were four pre-operative/day case admission chairs separated by partitions with a single sex changing room and toilet. There were five recovery beds and three recovery chairs. There were two operating theatres. At the time of our inspection, the treatment centre had very recently completed building renovations to the endoscopy suite in order to comply with Joint Advisory Group recommendations and achieve accreditation. Surgical specialties included day case ophthalmology, oral surgery, ear, nose and throat, general surgery, orthopaedic (minor), gynaecology and urology.

All day patients, including endoscopy, are admitted, recovered and discharged from the post-anaesthetic recovery unit. The centre also had a dedicated endoscopy suite, which has its own self-contained endoscope washer disinfector for decontamination. Endoscopy included upper and lower gastrointestinal, rectal bleeds and cystoscopies. A number of services were provided to the treatment centre by another Care UK facility including decontamination of instruments, pharmacy and in-patient surgery. Other services were outsourced to other providers including pathology, MRI/CT scanning, audiology, hard and soft facilities management and musculoskeletal physiotherapy.

Patient referrals were taken from NHS acute trusts in Bath and Swindon. During the period April 2015 to March 2016 there were 57 outpatient attendances and 22 surgical procedures completed for young people aged 16-18 years. These included 14 dental extractions plus one gastroscopy, 1 arthroscopy, one septoplasty, one colonoscopy, one ligation of varicocele and one varicose vein operation.

During this inspection we looked at surgery and the outpatient and diagnostic imaging service.

We inspected the treatment centre as part of our routine comprehensive inspection programme for independent healthcare services. We carried out a comprehensive announced inspection on 13 and 14 September 2016 and an unannounced inspection on 21 September 2016.

The registered manager and accountable officer for controlled drugs for Devizes NHS Treatment Centre was the treatment centre director, who had been in the post since August 2011.

During this inspection we looked at surgery and the outpatient and diagnostic imaging service.

Our inspection team

Our inspection team was led by: Ruth Bryant, Inspector, Care Quality Commission

The team consisted of two CQC inspectors plus three specialist professional advisors including a consultant surgeon, a theatre nurse and an outpatients nurse.

Summary of this inspection

How we carried out this inspection

To get to the heart of patients' experiences we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• It is well-led?

To carry out this inspection we used a variety of evidence sources. The organisation provided us with detailed information prior to our inspection including for example, data from audits, patent satisfaction surveys, minutes of meetings, staffing figures.

We visited the treatment centre on Tuesday 13 and Wednesday 14 September 2016. We returned for an unannounced visit on Wednesday 21 September 2016, to observe treatment. During our time on site we spoke with patients and staff including the treatment centre director, the medical director, the head of nursing and clinical services manager and the clinical governance manager.

We held one drop-in session for all staff in the treatment centre to attend. We talked with doctors, the nursing and healthcare staff, members of housekeeping, administration and support staff. We inspected all areas of the treatment centre including wards, waiting areas, theatres, outpatient consultation rooms, diagnostic imaging rooms. We spent time observing care in the operating theatres, outpatients department, the diagnostic imaging department and day-case ward. We reviewed policies and procedures, training and staff records and patient records where necessary. We collected comments cards completed by patients, carers and staff during our on-site visit.

Although the surgery service and the outpatients and diagnostics service are inspected as separate core services in this report, the patients at Devizes NHS Treatment Centre follow a joined up pathway of care whereby patients were seen as outpatients before and/or after their surgical intervention. Governance structures were shared across both services.

Information about Devizes NHS Treatment Centre

The Devizes NHS Treatment Centre was registered for diagnostic and screening procedures, surgical procedures and treatment of disease, disorder and injury.

During April 2015 to March 2016, there were 6,075 day case episodes. The most commonly performed surgical procedures during this period included; dental extraction (1,639), gastroscopy (936), colonoscopy (892), cataract surgery (485), hernia (183), arthroscopy (161), peri-anal procedures (115), operation on eyelids (109), operations of skin (104) and operations on hands (93). During the same period diagnostic imaging appointments accounted for 32.07% of outpatient attendances, followed by orthopaedics at 12.98% and ear nose and throat at 11.94%. During April 2015 to March 2016 there were 13,463 adult outpatient appointments, of these 5,347 were first appointments and 8,173 were follow-up appointments.

At the time of our inspection, the treatment centre employed 77 staff.

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	N/A	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

Devizes NHS Treatment Centre provides routine, non-urgent elective surgery for adults and dental procedures for young adults aged between 16 and 17. Patients have to meet eligibility criteria to ensure their safety and surgery is not considered appropriate for patients who are assessed as potentially needing high dependency care following surgery.

All patients are treated as day cases, there are no facilities for overnight stay, although arrangements are in place to ensure safe transfer of patients to a sister treatment centre or a local acute NHS treatment centre if they require a longer recovery time.

The service comprises two operating theatres and a dedicated endoscopy suite, which has a dedicated endoscope washer disinfector for decontamination of medical devices. There is a post-anaesthetic recovery unit with four pre-operative/day case admission chairs, separated by partitions, with single sex changing rooms and toilets. They are also five recovery beds and three recovery chairs within the recovery unit.

Surgery provided includes orthopaedic surgery, dermatology, dental, ear, nose and throat, gynecology and ophthalmology.

Between April 2015 and March 2016 there were 6,075 day case procedures carried out. The five most common procedures performed were:

- Dental extraction (1,639)
- Gastroscopy (936)
- Colonoscopy (892)
- Cataract (485)
- Hernia (183)

The theatres are open Monday to Saturday between 7am and 5pm, with surgery taking place between 8am and 4pm.

During our inspection we visited all surgical areas, including theatres, recovery areas and the endoscopy suite. We spoke with 16 members of staff and five patients, and reviewed three sets of records.

Good

Surgery

Summary of findings

We rated surgical services as good overall because:

- Staff understood and fulfilled their responsibility to report incidents. There was shared learning from incidents, both locally and throughout Care UK.
- Monitoring patient safety was a high priority and there were effective systems in place for doing so.
- Treatment was provided in line with national guidance and any updates were made known to all staff.
- Staff were supported by senior management and policies were in place which offered clear guidance on all relevant practice.
- Staff treated patients with dignity and their thoughts, feelings and wishes were considered when treatment was provided.
- Training was provided to staff which supported them to deliver care that was safe and of a high quality.
- Feedback from patients about the care they received was positive. Staff were seen to be kind and caring with a focus on individualised patient care.
- Patient's needs were met through the use of effective planning. The admission and discharge of patients was well organised which enhanced the patient's experience.
- The provider investigated complaints and responded to them in a timely manner. Learning was shared to improve and develop practice.
- Governance processes were clear and ensured quality, safety and care were monitored. Regular meetings and reporting ensured that performance and risks were understood by staff at all levels.
- Leadership within the service and at each level was seen to be visible, approachable and responsible. Staff were confident in the leadership and felt able to raise concerns.

However:

- Patient's confidentiality was not always maintained when they were admitted to the centre.
- The risk register was not in a format which made it easily readable or useable and it included outdated risks.
- Store rooms within the centre were not always suitable for the stock contained in them, which could pose a safety risk in terms of infection control and fluids being fit for purpose.

Good

Surgery

Are surgery services safe?

Good

We rated surgical services as good for safety because:

- The provider promoted a culture of openness and transparency. Staff understood and fulfilled their responsibilities to report incidents. There was learning from incidents. Staff were aware of their responsibilities under the duty of candour.
- Staff had received up-to-date training in safety systems. Compliance with mandatory training was between 90 and 100%.
- Premises and equipment were clean and staff took responsibility for checking equipment before every use.
- The electronic patient record system allowed easy but secure access for all staff and records contained all relevant information, which was clear and complete.

However:

- At the time of the inspection there was no thermometer in a storage room where intravenous fluids were kept and no record of the temperatures within that room, meaning there was no way of knowing whether the fluids being stored in that room had been kept safe for use.
- There were no minimum or maximum temperature audits for the rooms in which medicines were stored, although temperatures were logged. We could not be assured that medicines were safe to use.
- The layout of the theatre, specifically the location of the scrub sink, created a risk of the spread of infection as both clean and dirty instruments were transported past the sink before and after surgery. However, the rate of infection at the centre was very low and there was evidence the risk had been identified and recorded on the surgical departments risk register. Measures had been put in place to review the risk annually or if the risk of infection increased.

Incidents

- The provider had a policy for reporting and managing incidents which defined incidents and how they should be reported. An incident was described, in the policy, as 'an event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to patients, staff, visitors, members of the public or organisation'. Staff told us that they were encouraged to report incidents, had learned from recent incidents that had occurred at other treatment centres within Care UK and could clearly describe what an incident was.
- Senior staff informed us that all staff within the centre had undergone their incident reporting training and when questioned, staff were able to describe the reporting process, which was done using an electronic reporting system, or on paper if the computer system was down.
- There were 31 clinical incidents reported in the surgical department between April 2015 and March 2016, none of which were classified as serious. The vast majority caused no harm, 11 caused a low level of harm and one caused moderate harm.
- A never event took place in June 2016, which involved the incorrect extraction of a tooth. A never event is a serious incident which is wholly preventable as guidance and safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. This event was under investigation at the time of the inspection using root cause analysis, although senior staff informed us that the incident occurred because of human error and not because of a failure in process. As a result, the details of the incident were shared amongst staff shortly after it occurred and new practices were put in place to reduce the risk of the same incident occurring again. In dental surgery a consultant was now expected to mark the surgical drapes to highlight the tooth being extracted. In addition one of the nursing staff should now be shown which tooth is being extracted and asked to confirm, using the World Health Organisation (WHO) safe surgery checklist and consent form before any treatment takes place. The WHO safe surgery checklist identifies three phases of an operation, each corresponding to a specific period in the normal flow of work, before the induction of anaesthesia ("sign in"), before the incision of the skin ("time out") and before the patient leaves the operating room ("sign out"). In each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before it proceeds with the operation.
- Care UK used a tool to share learning across locations. For example a treatment centre in another location had used an incorrectly diluted eye solution during a

procedure. Procedures were amended following the incident and these learning points disseminated to all Care UK sites. Staff at the treatment centre were aware of this learning. At the monthly governance meeting, teams had discussed an information governance incident that had occurred in the radiology department of another Care UK site. This learning was detailed in the minutes for staff at Devizes to access.

- If a serious incident took place a root cause analysis was conducted by those who were responsible for investigating the matter. We saw evidence of root cause analysis being carried out as a result of two different incidents, which resulted in harm to patients, a venous thromboembolism and an eye infection. The process involved an investigation using detailed templates, which had been completed in significant detail. The cause of the infection was found and actions were implemented to reduce the risk of it occurring again. The investigation into the venous thromboembolism revealed that it was caused by rare complications associated with the procedure carried out and not through poor medical practice. Root cause analysis is an investigation into how and why patient safety incidentshappen. The analysis is used to identify areas for change and to develop recommendationswhich deliversafer careto patients.
- When things go wrong, thorough, prompt and robust investigations were carried out. Staff told us that shortly before the inspection, an incident occurred where the head rest of a theatre table had become detached while a patient was on it. The patient was anaesthetised at the time but their safety was managed accordingly as they were woken up and transferred to a local acute NHS trust. The incident was reported immediately and escalated to the medical director and head of nursing and clinical services. The theatre table was taken out of commission, all staff were made aware of the incident and an investigation into the matter was commenced with staff being made aware of any developments. The manufacturer also carried out an independent investigation. The patient had not been seriously injured as a result of the incident.
- Feedback from incidents was shared with staff and learning was cascaded through governance meetings, team and departmental meetings, one to one meetings and emails.
- The medical director informed us that mortality and morbidity meetings took place bi-monthly when governance meetings took place. A mortality and morbidity meeting is used to review and discuss patient deaths and complications for the purpose of identifying recurring issues and areas of improvement, in order to reduce or avoid negative patient outcomes. There were no deaths at the centre between April 2015 and March 2016.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the healthcare provider to notify the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. There was a duty of candour policy and all staff told us that they had received training. They confirmed that it was always followed where applicable. Senior staff informed us that patients were told when things go wrong, offered apologies and invited to meetings to discuss the events. Staff stated that the meetings were attended by the patients, a member of the senior management team, a consultant and staff involved in the event, if appropriate. A written account of the meeting was provided to the patient after the meeting and they were asked for further comment. The duty of candour was followed after the never event occurred. We saw that the duty of candour had been followed in all instances.
- Staff spoke confidently about the duty of candour and were able to explain the process. Staff told us they were encouraged to adopt a culture of being honest with patients and apologising when things went wrong and understood their responsibility in relation to the duty of candour.
- Any lessons learnt from the process were shared at monthly governance and departmental meetings.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- As patients undergoing surgery at the treatment centre were day cases the safety thermometer was not used. The NHS Safety Thermometer is usually used on inpatient wards to provide a ‘temperature check’ on harm, that can be used alongside other measures of harm to monitor local and system progress in providing a care environment free of harm for patients. It specifically looks at safety issues related to pressure ulcers, falls, catheters and urinary tract infections.

Venous thromboembolism (VTE) risk assessments took place throughout April 2015 and March 2016 and all appropriate patients had been risk assessed during that time period. Although this information was not displayed on patient boards.

- In the period between April 2015 and March 2016 there were ten incidents of non-compliance with the centre's VTE policy. Of the ten, five were related to local injections to a joint and did not require a VTE assessment and five were either not completed or not saved by the staff as a result of human error. An action plan was produced and further training was delivered to ensure staff completed them.
- The VTE data was extracted from the electronic patient record system and was presented by the clinical effectiveness manager at clinical governance meetings every month. The VTE information was cascaded to staff at the centre, by staff representatives who attended the clinical governance meetings, by presentation and was also circulated in the clinical governance meeting minutes. Information collected on VTE rates was submitted to the NHS at Clinical Commissioning Group (CCG) meetings.
- The rates of VTE were low. There was only one incident of a treatment centre acquired VTE throughout the reporting period. This was thoroughly investigated and it was determined it had not occurred as a result of treatment provided by the consultant or the staff at the centre. The risk assessment that had been carried out at pre-admission had been completed correctly and prophylactic treatment was not indicated before, during or after surgery. The conclusion was that the incident could not have been avoided.
- Consultants informed us that they assessed patients at risk of a VTE and if needed prescribed and administered deep vein thrombosis (DVT) prophylaxis in line with policy. Admitting consultants were responsible for ensuring that appropriate prophylaxis was provided. Patients were verbally advised on VTE prevention as part of the admission process. They were also provided with leaflets on discharge if VTE prevention has been required. The centre implemented the NHS VTE assessment which ensured that consultants completed a management plan prior to discharge, which was signed for and reflected any changes which were informed to the consultant at discharge.

Cleanliness, infection control and hygiene

- There were policies, systems and practice to prevent cross infection. During our inspection all areas of the treatment centre we visited appeared visibly clean. The floors of the theatre and post- anaesthetic recovery unit had laminated flooring although there were concerns from staff that areas of the floor in the corridors looked dirty. Staff told us that the floors had been deep cleaned but were due to be chemically treated to remove any stains.
- We saw staff following the treatment centre policies in respect of infection prevention and control. They were all bare below the elbow, and we observed staff using personal protective equipment and washing their hands when providing patient care. There were hand disinfectants available and accessible to all staff, patients and visitors on entering and exiting the post-anaesthetic recovery unit, theatres, at each recovery bay, admission bays and at the nurses' station. Nursing staff and consultants had access to gloves and they were available at the nurses' station and next to bays.
- There was an infection prevention and control manager who was employed, specifically to monitor and manage risk at Devizes NHS Treatment Centre and the inpatient facility at Bristol. The manager reported directly to the Clinical Governance Manager and the deputy director for infection prevention for Care UK. The manager was supported by an infection prevention and control lead that was responsible for the daily monitoring and management throughout all areas. The manager was responsible for delivering training to staff which comprised of face-to-face sessions and e-learning, the compliance rate for which training was 100%.
- There was an audit programme for infection control which was in date and completed in line with policy. The audits were carried out quarterly, with a spreadsheet completed to demonstrate when each audit had been carried out.
- The audit programme included the following: infection prevention and control; management, staff and training governance; General environment (June audits for endoscopy, post-anaesthetic recovery unit and theatres scored 100%, 100% and 96% respectively), sharps handling (June audits scored 100%); personal protective equipment (June audits scored 100%); operating theatre (fully audit); asepsis, surgical scrub technique (July audits scored 100%); hand hygiene and training (June audits scored 100%).

- The infection prevention and control manager had overall responsibility for the audit programme, monitoring of infection rates, identifying risks and investigating non-compliance. They met with the deputy director for nursing to discuss the infection prevention, audits, rates and non-compliance.
- The infection prevention and control manager told us that they were a member of an antimicrobial stewardship committee which met quarterly to discuss risks and management across both Devizes NHS Treatment Centre and the inpatient facility at Bristol. The other group members included the medical director, an anaesthetist, a pharmacist, the head of nursing and an orthopaedic consultant.
- The treatment centre had a policy which stated that equipment should be cleaned after every use. The infection control lead promoted a culture of personal responsibility in visually checking that equipment was clean before use. Staff informed us that they always visually checked that equipment was clean before use. We observed staff cleaning recovery and admission bays, including all equipment, after patients had used them.
- Within theatres and the post-anaesthetic recovery unit waste was segregated so that all clinical waste was put into orange waste bags and taken to the waste storage room. From the waste storage room, the waste was taken to the waste collection point at the rear of the building. The waste was taken out of theatre and into the same corridor that clean equipment was transported. The infection prevention and control manager told us that this was being risk assessed although we were not provided with any evidence of this.
- Patients were risk assessed for Clostridium difficile and/or Methicillin resistant Staphylococcus Aureus (MRSA) during their pre-admission clinics. There were no incidents of MRSA or Clostridium difficile between April 2015 and March 2016. The majority of patients attending the centre did not require screening for methicillin-resistant staphylococcus aureus (MRSA); however, those who did were screened during their outpatient consultation. Patients were asked if they had been in contact with any potential risk sources as part of the screening process. When a patient tested positive for MRSA, surgery was postponed until the patient tested negative.
- Surgical site infections were monitored and recorded. There were no surgical site infections resulting from orthopaedic and trauma, gynaecology, upper gastro-intestinal and colorectal, urological, ENT, general surgery and oralprocedures between April 2015 and March 2016. However, there was a surgical site infection related to ophthalmic surgery. Following a thorough investigation of the incident, looking at all risk indicators, it was determined that the infection was likely a result of a failure in hand hygiene by the patient when using post-operative eye drops. As a result patients were given a leaflet on the importance of hand hygiene on discharge. All identified infections had been investigated and any learning had been cascaded to staff.
- The scrub sink was located outside theatre one and on the corridor leading to the post-anaesthetic recovery unit, theatre two and all other areas of the centre. It was not protected in any way when dirty instruments and waste were transported out from theatre, which was in the vicinity of the scrub sink. We were provided a risk assessment which had been carried out in August 2016. The assessment determined that all necessary controls were in place to minimise any infection risk. We saw evidence the risk was on the surgery risk register but had been classified as a moderate risk which differed from their recent risk assessment which classified it as a high risk and therefore should be reviewed regularly. The risk assessment stated that further controls were required which included constant monitoring of outcomes and reviewing the sinks in the event of refurbishment opportunities.
- There were boxes of consumable supplies and medical devices on the floor of the store room which could be a potential risk of infection if the floors are dirty. Boxes containing consumables and medical devices could become contaminated and stored on shelves next to clean stock which when used could be transferred to patients.

Environment and equipment

- There were systems in place to ensure equipment was maintained and fit for purpose. We saw resuscitation equipment available in the post-anaesthetic recovery unit but not in theatres. The resuscitation trolley held two defibrillators, although staff were unable to tell us why there was only one trolley and why there was not one available in theatre. This had been risk assessed

and it was determined that the centre only needed one trolley. The trolley was easily accessible to theatre staff but could cause an issue if two patients were unwell at the same time and required use of the equipment. The trolleys were checked daily and all portable equipment had been serviced within the last year.

- The theatres were well equipped. A full theatre audit was carried out twice a year and any issues identified were reported to the theatre lead. All of the equipment within theatres and the post-anaesthetic recovery unit had been serviced and maintained in line with policy at the time of the inspection.
- Safety checks on all equipment within the treatment centre were carried out by an external company and took place once a year. The building maintenance was carried out by a second external company and senior staff informed us that any issues were reported to them at the earliest opportunity.
- It was the theatre lead's overall responsibility to ensure theatres had appropriate levels of stock and equipment. The anaesthetic lead was responsible for anaesthetic equipment. The stores were checked weekly and monthly, with audits being completed to ensure that stock and equipment were at suitable levels. Audit results were added to a register which was reviewed monthly by the theatre lead. If theatres were running low on specific items or needed to be changed the theatre or anaesthetic lead contacted the store manager/administrator, based at the inpatient facility at Bristol, for replenishment.
- The sterile equipment for theatre was provided by sterile services unit (SSU) at the inpatient facility at Bristol. The lists for surgery were prepared two weeks in advance which enabled staff to plan for and order equipment from the SSU. Requirement lists were prepared and discussed by the theatre lead and lead for SSU seven days in advance of surgery, in order to ensure the appropriate equipment was available. If there were any issues with equipment or surgical instruments it was discussed at weekly meetings and addressed in advance of the planned surgery. The required equipment, along with two additional sets, were delivered to the centre 24 hours before it was required, which was in line with the Association for Perioperative Practice (APP) requirements. All equipment was scanned into an electronic system that could trace where it was across the centre and the inpatient facility at Bristol. The centre also operated a paper based system if the electronic system failed, as a contingency. Contaminated equipment from theatres was transported in trollies from theatres to the dirty utility room within the theatre department. When ready for collection the trollies were wheeled to the rear of the building and loaded onto transport vehicles to be taken back to the inpatient facility at Bristol for cleaning and sterilisation.
- Staff informed us that they were able to run the theatre service with the equipment they had but required additional equipment for ear, nose and throat procedures. We were told that, on occasions, the centre borrowed a laryngoscope from a different treatment centre within Care UK as they did not always have one available at the centre or at the inpatient facility at Bristol. After use the scope was sterilised at the SSU before being transported back to the sister site.
- The treatment centre did not have Joint Advisory Group (JAG) accreditation for its endoscopy service. JAG accreditation is the formal recognition that an endoscopy service has demonstrated its competence to deliver against measures in endoscopy standards. The provider provided evidence that these standards were being worked towards as they had extensive building work carried out and had introduced new protocols in order to comply with JAG requirements. This included building a new patient room with en suite facilities and altering the patient flow into and out of the endoscopy department. The endoscopic equipment was cleaned and decontaminated onsite as the department had its own sterilisation unit.
- When an issue with the environment, equipment or facilities had been identified it was reported to the theatre, anaesthetic or sterilisation services lead, for rectification. From that point the matter would be escalated to the appropriate senior management team member. Decisions on how to rectify a problem would be discussed at governance meetings and based on urgency, patient safety and available capital.
- The centre participated in the Patient Led Assessment of the Care Environment (PLACE) audit annually which was undertaken by 'expert' patients provided by the local Healthwatch and Patient Forum. The centre's PLACE scores were higher than the England average for cleanliness (100%) and condition appearance and maintenance (100%).

Medicines

- Medicines were managed and administered safely. We observed good medicines practices within the centre as staff adhered to the centre's policy on medicine management, ensuring patients were kept safe and well advised. Medicines were supplied by the pharmacy located at the inpatient facility at Bristol. The service was available to the centre during opening hours.
- There was a medicines management structure in place for governance, audit, reporting, supply, safe management and administration of medication. Audits of the medicines management system were carried out annually. The centre achieved a 98% compliance rate for administration, errors, incidents and recall and 100% compliance rate for stock control for June 2016.
- Medicines, including controlled drugs, were stored securely. Medicines used on the post-anaesthetic recovery unit (PACU) were stored in locked cupboards in the clean utility room, which was locked when not in use. Access to the room was limited to those who knew the code. The keys for the locked cupboards were kept in a lockable cupboard in the room and the key was kept by the PACU lead.
- We observed staff administering medication safely. Controlled drugs were appropriately stored and monitored to ensure safe practice was maintained. There was a log book for all controlled drugs which had been completed correctly. The staff within the PACU described the disposal process for controlled drugs which were only part used. This process ensured safe practice as any unused drugs were disposed of using sharps bins or medical disposal bins. The amount of wastage was recorded in the controlled drug log book and witnessed by a second member of staff. We observed this practice during our inspection.
- Allergies were recorded in patients' electronic patient care records and on individual drug charts.
- Staff informed us that patients' medicines were ordered and delivered seven days prior to admission from the pharmacy department at the inpatient facility at Bristol. We observed these medicines being stored securely in the clean utility room on the PACU. If surgery was cancelled the medicines were stored until the rearranged date for surgery, if it was carried out within seven days, or if rearranged outside seven days, returned to the pharmacy department.
- There were local protocols for the administration of antibiotics and pain relief for each speciality and for each surgical procedure. Staff told us that the medicines were prescribed by the treating consultants, ordered and kept at the centre seven days prior to admission. If patients required additional medication, there were medicines available in the clean utility room. These were prescribed by the consultant and administered by the registered nurses in the PACU.
- Senior staff informed us that there were service level agreements with local pharmacies which supplied medicines when required. Staff did not express any issues with the local pharmacies practice or performance.
- At the time of admission and discharge, patients were advised by a nurse on what medicines they needed to take, why they needed to take them as well as how many and how often. If patients had any questions about their medication the nurse answered them at that time or if they did not know the answer, they sought further advice from the consultant.
- Staff working within the consumable storage department were unable to confirm whether there was a policy in relation to the storage of intravenous fluids and they were unable to confirm who had overall responsibility for stock rotation. There was no audit of stock rotation in the post-anaesthetic recovery unit or theatre.

Records

- Individual patient records were written and managed in a way that kept patients safe. Each patient had a care record which was kept on an electronic patient record system which was accessed via computer terminals in theatre, the PACU and the endoscopy suite. The centre held few paper records; they included prescription charts, consent forms, National Early Warning Score charts and correspondence. Staff informed us that they often checked the patient record system before interacting with a patent but used the paper records when recording observations.
- Once a patient was discharged the paper records were sent to the inpatient facility at Bristol and scanned onto the electronic patient record system and archived at an offsite location. However, staff informed us that the paper records were not scanned onto the system immediately and this process could take up to a month. This could cause problems if a patient returned to the

centre beforehand scanning had taken place. This risk was on the centre's risk registered and had been assessed as being a moderate but possible risk. We saw no evidence that this risk had been mitigated.

- We reviewed five patients' records and saw all entries were dated, legible and complete. Patients' records included all pre-admission health checks, investigations and results, risk assessments and reviews. Admission records included National Early Warning Score, VTE assessment, prescription chart, anaesthetic record and theatre care. Records of patients' time in theatre were fully completed and included the WHO checklist.
- All appropriate staff at the centre had access to patients' records if required but records were secured safely on a computer system and could only be accessed with the correct login and password. Paper records were kept with the patient while undergoing treatment but were stored securely in locked drawers when not in use.
- Staff voiced mixed feelings regarding the electronic patient record system. They liked that the majority of information was accessible in one place but the system had been slow and had crashed on occasion. This meant that paper records had to be completed and transferred to the electronic system afterwards, which was inefficient as it duplicated work.

Safeguarding of adults and children

- There were systems, processes and practices in place and communicated to staff to safeguard adults from abuse. There was a safeguarding policy which was accessible to all staff. Staff demonstrated an understanding of their safeguarding responsibilities and familiarity with safeguarding procedures. Staff stated that if they encountered a situation where a safeguarding referral was to be made, they would discuss it with their department lead and/or the safeguarding lead, as well as following policy by contacting the relevant bodies to make ensure the patient was safe.
- There was a safeguarding lead that was accessible to staff at the centre, and who was trained to level four adult safeguarding and also belonged to the regional safeguarding network.
- There had been no safeguarding concerns reported to CQC between April 2015 and March 2016. All members of staff were required to complete level three adult safeguarding training as part of their mandatory training and had a compliance rate of 100% at the time of our inspection.
- Staff were also required to complete level two safeguarding of children as part of mandatory training, which at the time of our inspection had a compliance rate of 86%. The target for the centre was 90%.
- There was a policy in place for staff to follow regarding Female Genital Mutilation (FGM) and was part of their safeguarding training.

Mandatory training

- Staff received regular mandatory training updates to ensure the care and treatment they provided kept patients safe. Staff received mandatory training in PREVENT, fire safety, infection control, duty of candour, medicines management, safeguarding adults, advanced life support, patient consent and clinical governance, which at the time of our inspection had a compliance rate of 100%. Staff also received mandatory training in intermediate life support; equality and diversity; mental capacity act and deprivation of liberty standards; information governance; basic life support; moving and handling;safeguarding children. Compliance rates with training were not 90% but ranged between 86% and 97%. The compliance target within the centre was 90% but staff told us they were chased and encouraged to complete their training.
- The centre had a designated training lead and the local clinical lead at the monitored staff practice.
- Staff were encouraged to complete their mandatory training in a timely fashion, and an audit was carried out to monitor compliance. Staff told us that they had sufficient time to complete their mandatory training, which they completed during the monthly governance days.
- The clinical lead told us that they were responsible for ensuring all staff at the centre had completed their mandatory training. Compliance with training was monitored using a spreadsheet which was regularly checked by the clinical lead.

Assessing and responding to patient risk

- There were systems in place to ensure that individual patient risks were identified and managed safely. Patients' care and treatment was consultant led which meant each patient's consultant was the person in

charge of their care and undertook any and all post treatment reviews. The service only carried out day case surgical procedures so patients were, in the majority of cases, discharged the same day. Following discharge, patients could access a 24 hour help line, through which they could contact nursing staff and/or the resident medical officer at the inpatient facility at Bristol.

- Following referral to the centre, all patients were screened using the centre's admission criteria to ensure that only suitable patients were admitted for treatment. This involved assessing the patient's risk, taking into account their previous and current health conditions. Patients attended a pre-admission clinic, at which all of their health information was reviewed. A series of risk assessments were then completed; including venous thromboembolism, nutrition and discharge planning, which were reviewed / repeated on admission. If any health issues arose, that required further investigations, testing and/or diagnostic imaging; this would be arranged prior to admission. Results of the pre-admission investigations were reviewed to assess suitability for surgery. On admission, patients were also asked if any changes had occurred since their pre-admission clinic.
- The centre did not provide care and treatment for patients who had complex needs or needed a level of care which the treatment centre was not staffed or equipped to provide. The patient safety inclusion criteria excluded the following patients:
  - Under 16 years of age (patients aged 16-18 must be over 40kg in weight);
  - High suspicion or diagnosis of cancer;
  - Clinical emergencies;
  - Unstable America Society of Anaesthesiologists (ASA) 3 (i.e. poorly controlled co-morbidities);
  - Pregnancy;
  - Body Mass Index (BMI) 42 for general/regional anaesthesia subject to individual assessment or 45 for local anaesthesia.
- A new pathway was introduced whereby every patient under eighteen was reviewed by the registered special children's nurse (RSCN). The RSCN then convened a multidisciplinary meeting to discuss and arrange reasonable adjustments if the young person presented with additional requirements. Compliance against the standard operating procedure for young adult was reviewed in August 2016. It was identified there was inconsistent adherence to the triage process, specifically, that multidisciplinary meetings were not documented and that no specific letter for young adults was in use. Some actions were completed to rectify this non-compliance and some were due for completion after our inspection.
- Following surgery patients were taken from theatre to the post-anaesthetic recovery unit to recover and await discharge. Patients were closely monitored by two registered nurses and a health care assistant. Should a patient's condition deteriorate or the patient was not considered well enough to be discharged the same day, the patient would be transferred to the inpatient facility at Bristol, where there were inpatient facilities or to a local acute treatment centre. Escalation protocols were in place for those transfers and staff were clear about their roles and responsibilities in those transfers. Staff were required to call 999 in the case of an emergency urgent transfer to a local NHS treatment centre.
- We reviewed patient notes and could see that staff used the National Early Warning System (NEWS) to monitor patients post-surgery to identify deterioration in health. This is a series of physiological observations which produce an overall score. The increase in score would indicate deterioration in a patient's condition. A plan was available in each patient's record for staff to follow if the scores were to increase. Patients with a high NEWS score were continuously monitored, a full assessment would be carried out to determine condition and transfer to another facility would be considered. All of the patient records we reviewed were completed appropriately.
- The centre carried out audits of patient records before, during and after surgery; reviewing whether staff had completed all assessments, consent, recovery and discharge documents correctly. The most recent audits demonstrated high levels of compliance, with scores between 99% and 100%.
- The theatre staff followed the five steps to safer surgery. This involved the completion of the surgical safety checklist before, during and after each surgical procedure. We visited theatres and observed the five steps to safer surgery checklist being completed on each occasion by all members of staff. We saw the checklist being used for cataract surgery, endoscopy and dental surgery.
- The theatre lead undertook an observational and documentation audit of compliance with the WHO safety checklist every month. Senior staff told us that if

and when there were any discrepancies action plans were put in place, attached to the audit and communicated to all staff. Data submitted by the centre demonstrated that the WHO safety checklist and documentation audits scored 100% for July 2016.
- The relevant managers presented the results of audit findings at monthly governance meetings as appropriate.
- The centre carried out individual risk assessments of patients at pre-assessment clinic and again on admission which included venous thromboembolism (VTE), pressure ulcer risk assessments, falls risk assessments and malnutrition universal screening tool (MUST). We saw evidence of these risk assessments being carried out in patients' records, where applicable.
- Resuscitation scenarios took place each month to enable staff to be well prepared in the event of a cardiac arrest. At the centre there were five staff trained in advanced life support (ALS).

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times.
- Post-anaesthetic care unit and theatre staffing levels were determined using an acuity tool. This linked activity and allocated nursing hours to each speciality ensuring the appropriate levels of staff were available. It allowed additional hours to be added if a patient required one to one care. Clinical judgement was recorded separately if more staff were required. Staffing was planned six weeks in advance and reviewed weekly. The actual levels of staff were updated daily and staff told us they felt appropriate staffing levels were met.
- The centre operated a theatre model which was based on core staff required per list. The model was linked to the theatre schedule and fed into the staff allocation list. The model was reviewed twice per year and with variation of activity. A red flag audit and associated dashboard were in place, which were discussed monthly to ensure safe staffing levels.
- On each day of our inspection there were at least two registered nurses and a health care assistant on the PACU while theatre lists were running which was sufficient to meet the planned theatre activity.
- Data provided by the centre showed occasional use of bank and agency nursing staff (less than 20%) between April 2015 and March 2016 in theatre departments. The use of bank and agency operating department practitioners (ODPs) and health care assistants (HCAs) working in theatre departments reached a peak of 32% in November 2015. However, there had been no agency nurses, ODPs or HCAs working in the theatre departments in the last three months of the reporting period.
- All new, bank and agency staff completed an induction process and online training to ensure all competencies had been met. They received one to one mentorship and training on the use of medical equipment and devices.
- In theatres the Association of Perioperative Practice Safety Standards (2011) were followed. Each theatre had an operating department practitioner, a health care assistant and two scrub practitioners per list as a minimum.
- We spoke with senior staff who confirmed the staffing levels varied dependant on planned daily activity. At the time of our inspection the staffing levels within theatre and on the recovery unit had been achieved for the identified level of activity. We observed recovery and saw that no more than two patients were in recovery at any time. During each day of inspection a senior nurse was on duty at all times on the ward.
- There were low rates of sickness within theatres for all staff groups. There were no unfilled shifts in January, February or March 2016. Senior staff told us that if a member of staff were absent they were able to approach the inpatient facility at Bristol and request appropriately qualified staff to cover.
- The senior leadership team had identified there appeared to be high staff turnover within theatres, specifically relating to ODPs and HCAs. However, staff leaver numbers were low but appeared high because of the small size of the team. Staffing numbers were safe and in line with activity and safer staffing models.

Surgical staffing

- There were adequate consultants in post to meet the surgical needs of patients. There were 20 consultant surgeons and anaesthetists employed at Devizes NHS Treatment Centre. The majority of consultants were working full time at the centre and were directly employed by Care UK. There were a small number of consultants working at the centre on a self-employed basis. The self-employed consultants could only practice at the centre if they agreed to follow the centres

policies and provided evidence of appropriate skills and registration. The vast majority of consultants worked for Care UK directly and so received their appraisal and revalidation through the centre. The medical director was responsible for all revalidation and appraisals of all consultants, employed by Care UK .The self-employed consultants forwarded their revalidation and appraisal documents from their responsible officer to the centre. Responsible officers are individuals who hold responsibility for ensuring consultants have the necessary registration and documentation to provide medical treatment, including carrying out appraisals, revalidation and managing any restrictions on their practice. All consultants practicing at the centre had been revalidated at the time of our inspection.

- All surgery at Devizes NHS Treatment Centre was provided by consultants. This meant that consultants were responsible for their own patients. The centre employed bank consultants to cover any annual leave or gaps. The bank consultants were either employed directly by Care UK or on a self-employed basis. We saw that all bank consultants had the necessary documentation in place, including disclosure and barring service checks, appraisal and registration documents.
- Each consultant and anaesthetist saw their own patients pre and post operatively and were available on call until the patient was discharged from the centre.
- There were no resident medical officers on site at the centre, however, there were five based at the inpatient facility at Bristol, who were available for advice via the 24 hours helpline for patients treated at Devizes NHS Treatment Centre. They also managed any patients for re-admission or transfer to the inpatient facility at Bristol from Devizes NHS Treatment Centre. Consultants also remained at the site until their patients were discharged so were available to offer advice, treatment and support if patients experienced any issues with their recovery.

Major incident awareness and training

- A major incident policy and plan were in place at the centre. It was the responsibility of the most senior person on duty to take charge of the incident and manage the process in line with the emergency response procedures, which included notifying the treatment centre director and/or senior manager on call.
- The centre had an emergency generator which was checked weekly. We saw fire alarms were tested weekly.
- Security staff were present at the centre at night from 6pm and a panic button was available at reception in order to summon help.
- The centre doors were secured when the centre closed at approximately 6pm every day. After this time there was access to the building by intercom.
- Theatres were all locked at night with keys stored securely.

Are surgery services effective?

Good

We rated surgical services as good for effective because:

- Treatment was provided in line with national guidance and staff were aware of the relevant National Institute for Health and Care Excellence (NICE) guidelines. Policies and procedures were in place to support staff and compliance with them was monitored to ensure consistency of practice.
- Patients had comprehensive assessments of their needs before and during admission.
- Some information about patient care and treatment and their outcomes was collected and monitored. There was not always sufficient data to submit to national audits but local audits were undertaken.
- Staff assessed and managed patients' pain.
- Staff were trained to enable them to effectively carry out their roles.
- Staff teams and services worked together to provide coordinated care.
- Consent to care and treatment was obtained in line with legislation and guidance.

Evidence-based care and treatment

- Care and treatment was provided in line with guidance from National Institute for Health and Care Excellence (NICE). A central Care UK team supported all care centres to ensure that staff were updated and informed the treatment centre of any and all changes to NICE guidance. NICE guidance was accessible to staff via the centres' shared IT drive which staff could access at the centre and at home. We saw evidence that NICE clinical guidance for surgical site infections (CG49) was

accessible and that the guidance was being followed. We saw evidence that NICE guidance was being discussed at clinical governance and departmental meetings.

- The medical director held responsibility for ensuring NICE guidance was followed and any changes were cascaded to consultants electronically, at clinical governance meetings monthly and surgical specialty meetings bi-monthly. Staff stated that they followed NICE guidance and that they were notified of any changes at departmental meetings, email and speciality meetings. If NICE guidance was not being followed by staff then intelligence would be gathered and highlighted to the responsible parties by the medical director. Any trends in failures to follow guidance were reviewed and action plans implemented to ensure compliance.
- Patients undergoing hip and knee arthroscopy, groin hernias and varicose veins surgery consented to their data being submitted to the patient reported outcome measures (PROMS) database. The results of PROMS were benchmarked against other treatment centres within Care UK, other independent providers and local NHS trusts. Benchmark data was used to compare outcomes with other providers to ensure learning and continuous improvement of outcomes.
- All key performance indicators and outcomes were reported to all responsible Clinical Commissioning Groups (CCGs). The key performance indicators were also reported centrally to Care UK head office with trends and key elements shared at quality assurance governance meetings each month. Outcome data also formed part of the scorecards for consultant's revalidation, with data being reviewed on patient outcomes, returns to theatre, revisions, VTE and infections.
- An audit committee was accountable for all clinical audits undertaken at the treatment centre. Senior staff told us that all audit and outcomes were reported, investigated, trends analysed with lessons learnt being presented at local clinical governance meetings. We saw evidence of lessons being shared at clinical governance and departmental meetings, an example of this being that the centre had encountered an issue with an information governance breach concerning x-ray images. This matter was discussed at the governance meeting and it was decided that rather than copying images to CDs, the image exchange portal should be used as it is more secure.
- The medical director informed us that action plans were implemented to address non-compliance and results were reported to Care UK who produced benchmark reports measuring performance against nine other treatment centres. This included audits for VTE assessments, infections, WHO safety checklist compliance, incidents, risks, staff turnover and sickness. There were various groups to address falls, patient discharge, patient information, VTE and medication prescribing errors.

Pain relief

- We saw pain relief was discussed pre-operatively, in theatre and on the ward. As part of the WHO checklist it was clarified whether pain relief had been arranged. Post-operatively the level of a patient's pain was monitored, reviewed and recorded on the NEWS chart and action taken as required. While patients were in recovery, their pain levels were monitored regularly and competent registered nurses, administered appropriate pain relief to patients on the PACU when required and in line with Care UK policy. Nurse had been trained to administer pain relief and their competencies were reviewed and monitored to ensure safe practice. There was no dedicated pain team within the centre but advice was available from the patient's consultant, the clinical lead and if required the RMOs at the inpatient facility at Bristol.
- Patients we spoke with confirmed they were comfortable and pain relief had been well managed. Pain relief was managed to prevent pain impacting on recovery. We saw that 'as required' medicines were prescribed appropriately and recorded when given.
- Staff informed us that a patient's pain and discomfort was assessed, and then scored, and analgesia administered as per their prescribed medication regime. A 24 hour helpline was provided for patients and any feedback in relation to pain was recorded, managed and analysed appropriately. Patients were able to provide feedback on pain relief by completing an electronic feedback questionnaire on discharge.

Nutrition and hydration

- The provider used a nutritional assessment to risk assess each patient's level of nutrition and hydration; however, as only day case surgery was performed at the centre, patient requirements were minimal. Staff confirmed that there was no dietician at the centre but if risks were identified there were management guidelines provided for staff to follow.
- The provider captured nutrition and hydration needs during pre-admission and patients were asked to communicate their dietary and cultural needs. Food intolerances, allergies and medication contra-indications were taken into consideration and communicated to staff.
- If a patient required a meal following surgery the staff could place an order prior to admission which would be available after surgery had been performed. All information related to nutritional needs was recorded on the patient record system.
- Staff followed guidance on fasting guidance before surgery and instructions about periods of nil by mouth were given during patients' pre-admission visit. The information was also provided to the patient by telephone approximately seven days prior to admission. On admission, staff checked when the patient last ate or drank to ensure they were safe for surgery. Periods of nil by mouth were staggered in line with admission times.
- Patients told us their consultant had discussed their level of nausea with them. Staff told us that they reviewed patients in respect of nausea and vomiting whilst on the PACU.

Patient outcomes

- The provider uploaded data to the National Joint Registry for hip and knee arthroplastyand revisions, Patient Related Outcome Measures (PROMS) for hip and knee arthroplasty, groin hernias and varicose veins and surgical site infection rates for hip and knee replacements for Public Health England (PHE). They also participated in Patient Led Assessment of the Care Environment (PLACE), British Society Uro-gynaecology national audit and global rating scale (GRS) audit for JAG.
- For PROMS, the total figure for the centre for April 2015 to March 2016 for groin hernias showed, 91 patients were eligible, of which 53% reported improvement in health, and 11% reported that their health had worsened and 35 reported no change at all. This was higher than the England average.
- For varicose veins, there were 16 modelled records, of which 58% reported improvement in health and 12% reported worsening health.
- The medical director had responsibility for collating outcome information and presenting the information at Joint Service Reviews with the CCGs. The information presented included referral to treatment times, planned admissions and cancellation rates. As part of this process key performance indicators were discussed and any improvement plans implemented.
- The electronic patient record system allowed the medical director and the clinical governance team to easily monitor patient outcomes, volume of surgeries, re-admissions, infections, revisions, VTEs and overnight stays. The information could be presented as a whole for the service, specialties, as well as by consultant. This information was benchmarked and any issues highlighted in order to put actions in place to improve results.
- Outcomes were recorded in the centre's electric patient record and data could be exported for each surgeon, giving information on patient outcomes and key performance indicators. It was the responsibility of the clinicians and healthcare professions to record the outcomes in the patient record, from pre-assessment to discharge. Patient appointments were scheduled on the electronic patient records system to ensure long term outcomes were tracked.
- There were two cases of unplanned readmission within 28 days of discharge between April 2015 and March 2016. Data provided confirmed that these involved dental and gynaecological procedures. Both incidents were investigated which revealed that the readmissions and returns to theatre were unavoidable and caused by complications associated with the procedures performed. However, learning outcomes were communicated to staff which included re-circulating antibiotic and incident reporting policies.
- There were four cases of unplanned transfer of a patient to another treatment centre between April 2015 and March 2016, which was a relatively low rate, compared with other independent acute treatment centres.
- There was an established audit committee, which was chaired by the medical director and on which the head of nursing and clinical governance manager sat. Applications could be made by staff to create an audit which the committee then approved or rejected. If

approved, the audits were implemented and time frames were introduced to confirm when they needed to be completed by. The committee acted as the centres quality improvement committee.

- There was one case of a surgical site infection during the reporting period which concerned an eye infection following surgery. When investigated it was determined that it had not been caused by environment, procedure, consultant or health practitioner error but by the application of eye drops following discharge. As a result, leaflets were provided to patients, prior to discharge, on how to apply eye drops correctly and on hand hygiene.
- The treatment centre was working towards accreditation with Joint Advisory Group for endoscopy units and completed Global Ratings Scale census.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job and keep patients safe.
- Devizes NHS Treatment Centre had no consultants engaged under practicing privilege arrangements as all consultants were directly engaged on either an employed, bank or self-employed basis. Consultants were selected by face to face interview selection, principally based upon good medical practice in particular specialty.
- Pre-employment and pre-engagement accreditation of medical staff was in accordance with the NHS employment check standards including General Medical Council (GMC), Disclosure and Barring Service (DBS), occupational health, identity, right to work, qualification and reference checks. As part of the process the responsible officer routinely communicated with the previous responsible officer for all candidates to whom they offered employment or engagement. The induction process was managed by the medical director and specialty leads. No appointment was confirmed as substantive until rigorous evidence-based competency checks were successfully completed during the six month probationary period. On-going checks, such as GMC registration renewals, were managed centrally by the medical director, in accordance with the provider's clinical staff registration policy.
- As part of the probationary period any new consultant, wanting employment at the centre, was supervised during their first surgery, by the clinical director. If any substandard practice was witnessed the clinical director would take varying levels of action, depending on the issue. The clinical director would discuss the matter with the medical director and the consultant in question and take appropriate action, either by extending the probationary period, arranging further training or ceasing probation altogether and ending the association
- All endoscopy procedures were recorded and as part of the supervisory procedure, a random selection of DVDs of endoscopy procedures, for each consultant, were sent to the clinical director for review. This was to ensure practice was safe and in line with guidance which, according to data, demonstrated that it was.
- Any and all issues concerning consultant practice, revalidation and appraisal were dealt with by the medical director. Systems were in place to alert the medical director and their personal assistant when registrations were due and consultants' appraisals were received and recorded accordingly. Management staff confirmed that, should there be any delay in receiving proof of registration; the consultant would be suspended from practice until such time as proof was received.
- When a consultant was due their appraisal they would receive written confirmation asking them to attend a meeting with the medical director. All documentation on file for each consultant was reviewed at the same time as the appraisal to ensure compliance. The centre had an electronic programme for monitoring when appraisals were due.
- The medical director maintained relationships with bank and self-employed consultants' responsible officers. This was to ensure an oversight of appraisals and competencies appropriately satisfied.
- The medical staff records were held by the medical director. We were presented with evidence of medical staffing records and found the documentation complied with Care UK policy, as all documentation in respect of references, proof of professional registration, GMC registration, appraisal documentation and DBS checks were present and up to date.
- As part of the appraisal process the medical director discussed with each consultant, their individual scorecards which contained detailed information about the volume of surgeries performed, patient outcomes, readmissions, revisions, cancellations, infection and VTE rates. Both the medical director and consultant discussed their performance over the year and developed a personal development plan (PDP).

Applications for study leave were also reviewed, with the centre contributing funds to assist with payment of courses that were in line with the PDP. The medical director was aware of the number of surgeries a consultant had performed over the relevant period and was able to discuss whether or not consultants would be able to continue to carry out any of these at the centre. Any complaints or incidents relating to the consultant were also reviewed.

- Staff development plans were included in all staff appraisals. At the time of inspection, 100% of staff appraisals for nurses and health care assistants working in theatre and the post-anaesthetic recovery unit had been completed.
- Ward staff confirmed that they had been afforded training opportunities and were supported to attend training and requests for anything specific and related to their practice would be considered.
- Feedback provided by patients on staff competency came through verbal feedback, electronic survey and formal complaints. The information was logged and action taken by individual line managers.

Multidisciplinary working

- Staff within the surgical department worked together to ensure patients received treatment that was safe and of a high quality.
- Staff told us that they felt the teamwork within the theatre department and post-anaesthetic recovery unit was effective with good communication between departments, which aided handovers and patient care. During our inspection we observed nursing staff, healthcare assistants and consultants working effectively to deliver safe and high quality care.
- If a multidisciplinary team meeting (MDT) was required they were held to discuss individual needs and to ensure that person centred and appropriate care was delivered. Staff of all levels told us that they were able to call an MDT if required and when they have done so, all necessary staff attended. An MDT meeting consisted of healthcare assistants, nurses, operating department practitioners and consultants discussing a patient's care plan to ensure all measures were implemented to guarantee their treatment was safe. Records of MDT meetings were recorded in patient records.
- There was staff involvement in multidisciplinary working groups to help plan quality and safety improvements for patients.
- There was a policy which set out the roles and responsibilities in the event that a patient needed to be transferred to another treatment centre. This informed staff that there would be a multidisciplinary meeting where everyone's role in the transfer would be assigned.
- If community district nursing services were needed the ward staff would contact them via the patient's GP, prior to the patient being discharged.
- In the event of or suspicion of malignancy a cancer fast tract onward referral was made to the appropriate body. Staff within the endoscopic department told us they comply with the centre's policy.

Seven-day services

- The treatment centre ran a six day service, Monday to Saturday, for day surgery, endoscopy and radiology. Theatre sessions were scheduled six days a week running from 7am to 5pm, with operations taking place between 8am to 4pm.
- Out of hours there was a consultant on call for each specialty, including anaesthetics and radiology, these staff were based at the inpatient facility at Bristol, if required.
- Nursing staff and the resident medical officer were available to provide medical advice and guidance over the telephone 24 hours a day, seven days a week. Any significant concerns would be escalated immediately to the consultant on call. Patients were offered advice and brought back for assessment and/or readmission and review by a consultant if required.
- There was a theatre, pharmacy, physiotherapy and radiology team on call daily at the inpatient facility at Bristol.
- Additional consultant advice and support was available from local NHS treatment centres for hepatobiliary, geriatric, emergency services, pathology and microbiology issues.
- There was a senior manager on call rota providing cover 24 hours a day, seven days a week.

Access to information

- Staff always had access to information needed to deliver effective care and treatment to patients. Patients' full medical records were not available to staff, however a referral letter from patients' GPs included a minimum data set which contained the required information.
- Patients' care and treatment was recorded in an electronic patient record while in treatment centre. They

also had a paper record which contained observations, prescription charts, correspondence and their signed consent forms. The paper file travelled to and from theatre with the patient. Access to the electronic patient record was via computer terminals in the post-anaesthetic care unit, the endoscopy suite and in theatre.

- All of the paper records were kept on site until the patient's discharge. They were then sent to the inpatient facility at Bristol where they were scanned onto the electronic patient records system. Once scanned the paper records were archived at an offsite facility. Once scanned onto the system all medical staff had access to the records with login details and password.
- We observed files being received ready for planned procedures and being returned to secure cabinets which were locked with a key when not in use.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated understanding of their responsibilities in respect of consent and decision making requirements which was in line with legislation and guidance, specifically the Mental Capacity Act 2005.
- We saw that five consent records were fully completed and signed by the consultant and patient. Patients were advised by consultants on the risks, benefits and side effects of surgery.
- Consent was completed by the consultant at the pre-admission appointment and was also discussed again on admission. We observed in theatre, as part of the completion of the WHO safety checklist, consent was confirmed. We saw further consent had been obtained for patients' data to be included in the National Joint Registry.
- Staff received mandatory training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS). Staff within theatre and the ward had achieved 100% compliance. All policies in relation to MCA and DOLS were available in the clinical leads office and online and could be accessed at home.
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- During the pre-admission appointment patients were screened for dementia. Staff told us that they rarely encountered patients living with dementia but when they did, they followed Care UK policy. They explained if they encountered a patient living with dementia or any type of learning disability they ensured all necessary documentation was completed.
- Staff informed us that if a patient lacked capacity to consent to treatment, they completed a separate consent form and made decisions in their best interests. This was always recorded on the electronic patient records system. The form included an assessment of the patient's capacity and requested confirmation of the following: whether the patient was unable to comprehend and retain information material to a decision on treatment, whether the patient was able to use or consider the information in the decision making process, whether the patient was unconscious, whether a mental capacity assessment and best interest check had been completed, whether the patient had refused a procedure in a valid advance directive/decision document and whether colleagues and those close to the patient had been consulted. The form also requested information on why the healthcare professional judged the procedure to be in the patient's best interests, why the treatment could not be delayed until the patient recovers capacity, what the intended benefits of the procedure were and any associated risks.
- When questioned the majority of staff were able to explain their responsibilities under the Mental Capacity Act 2005 which was in line with policy.
- Records of patient's choices for resuscitation were not kept. The treatment centre's pre-assessment process for non-urgent elective surgery, considered all patients to be for resuscitation. For each patient who presents with a "Do Not Attempt Resuscitation" a record on their notes is made and a discussion between the patient and the Anaesthetist takes place.

Are surgery services caring?

Good

We rated surgical services as good for caring because:

- Patient feedback about the care provided was positive. We observed staff to be caring, kind and compassionate and with focussed person-centred care. Patients told us staff were courteous and treated them with respect.

- Patients were kept informed at all times about their treatment and felt included in the decision making process. This included both the admission and discharge process.
- Staff were helpful, kind and encouraging to patients, providing support whenever required.

However,

- Some private patient conversations between consultants and nurses could be overheard while in the admission bays in the post-anaesthetic recovery unit.

Compassionate care

- We spoke with five patients, who were all complimentary about staff and the care they had received. They told us that staff had been kind, caring and had treated them with respect.
- We observed staff asking to enter patient bays before entering and addressing patients respectfully by the name they had requested.
- The provider had a privacy, dignity and respect policy, which was accessible to staff and they were aware of its content. All clinical staff were responsible for ensuring the privacy and dignity of individual patients was maintained in line with policy. Senior staff told us that when recruiting staff they recruited individuals who could demonstrate they could fit into the culture of providing compassionate care.
- The centre used the friends and family test to capture patient feedback. The centre had scored between 99 and 100% throughout the April 2015 to March 2016. Patient feedback was also received through verbal discussions, comment cards, electronic submissions and social media.
- Patient satisfaction surveys were undertaken and the results collated and actions taken. Comments were seen to be positive. Feedback was provided to departments from surveys to promote continuous improvement. We looked at the patient satisfaction surveys and saw that the majority of comments were positive.
- When patients were admitted, they were escorted to admission bays which were partitioned by blinds. The blinds did not provide sound proofing so all discussions while in the admission bays could be heard in the adjoining bay, by the staff at the nurses' station and by anyone walking past. We observed consultants discussing surgery and consent issues with patients in the bays. A senior staff member told us that if patients wanted to have a private conversation a room would be made available to them.

Understanding and involvement of patients and those close to them

- All patients were involved in pre-admission assessments and completed a health questionnaire. Patients told us that their consultant discussed their treatment options and explained exactly what would happen during admission. We observed and were told by patients that they felt well informed and included in their plan of care.
- We observed that staff asked patients for consent before any activity, which when asked, was also confirmed by patients. We observed staff answering questions fully and checking that they had been understood.

Emotional support

- We saw staff were supportive and tried to support the patient's physical and emotional wellbeing. Patients were made comfortable and their questions were answered by staff at the earliest opportunity. Staff ensured patients experienced as little distress as possible.
- Patients told us that that staff regularly visited them and we observed staff regularly checking patients were comfortable.
- Staff told us that should a patient with learning disabilities be admitted, their carers would be enabled to stay and support the patient. This would be assessed at the pre-assessment clinic to ensure that all possible steps were taken to reduce distress and anxiety.
- After a patient was discharged the patient experience team made follow up telephone calls to patients within 24-72 hours to make sure patients were well and had recovered after their surgery.

Are surgery services responsive?

Good

We rated surgical services as good for responsive because:

- Services were planned to meet patients' needs.

- The flow of admissions and discharges through the treatment centre was well organised and in a timely way.
- The centre was meeting all referral to treatment time indicators.
- The needs of different patients were considered in the planning and delivery of the service. The provider was aware of further work needed to develop dementia care and was taking action to address this shortfall.
- Complaints were responded to in a timely manner and learning was used to develop future practice and improve the service.

Service planning and delivery to meet the needs of local people

- The treatment centre arranged and planned their surgical services which met the needs of their patients.
- Admission times for patients were staggered in order to reduce waiting times and to enable staff to manage admissions efficiently. Patients' addresses were taken into account when arranging admission times, and those living further away were given later times.
- Senior and ward staff told us that if the workload was anticipated as busy, extra staff would be arranged.
- Analysis of referrals was carried out to identify trends and patterns to identify who was accessing the service and whether any actions could be implemented to increase the level of referrals.
- The senior management team, which included the treatment centre director, medical director, head of nursing and clinical services, worked closely with their Clinical Commissioning Groups (CCG), GPs and acute trusts to plan services for the local population. This included regular contact with the CCGs to direct more patients to the centre. They were also raising awareness with local GPs to increase referrals. The senior management team had regular contact with acute NHS treatment centres to direct patients to them to reduce their waiting lists and to ensure patients were treated in a timely manner. The centre had service level agreements (SLAs) with local NHS organisations wherever possible.
- Facilities within the theatre and post-anaesthetic environment were well designed to meet the needs of patients with mobility difficulties. For example, there was adequate free car parking with marked disabled bays immediately adjacent to the treatment centre entrance, a wheelchair was available in the reception for patient use and all patient facilities were on one level.
- Staff told us that they provided advice to patients on smoking cessation and weight loss at their first consultation, pre-admission appointments and admission.
- The care centre was set in a single storey building which had wide access for patients using a wheelchair or walking aids.

Access and flow

- We observed access and flow at the treatment centre to be efficient and well organised.
- The patient information management system had real time incorporated into its patient pathway, which tracked the patient's journey through outpatients and theatre operating sessions. The aim was for the patient to be seen and given a surgery date within a three hour appointment slot. Achievements were extracted directly from the electronic patient records system and days and times where patient expectations had not been met were reviewed and actions taken to improve performance.
- The treatment centre met the national indicator which requires that 90% of NHS patients begin treatment within 18 weeks of referral by their GP for each month between April 2015 and March 2016. Scheduling and patient booking teams monitored waiting times on a daily basis, communicated concerns and added capacity when required, to ensure the wait time was within acceptable parameters. Specialities were actively monitored and waiting times were published to the local commissioners weekly. This kept the CCGs up to date on the wait time from referral to treatment as well as capacity issues or areas of low referrals.
- Overall waiting times were monitored using a bespoke tool which utilised the current waiting list, average referral numbers and number of clinical sessions available to estimate the waiting time for each speciality. The information was used to adjust the theatre lists scheduled to ensure waiting times remained at an acceptable level. Patient waiting times between outpatient appointment and surgery was no more than eight weeks, with indicative total waiting times from referral to treatment being no longer than 13 weeks.

- There were 16 cancelled procedures for non-clinical reasons between April 2015 and March 2016. The reasons for cancellations included consultant sickness and breakdown of equipment. Of these, 100% were offered another appointment within 28 days of the cancelled appointment. Staff told us that if surgery cancellations occur, the patient's consultant would discuss this with the patient at the earliest opportunity and arrange an alternative admission date. The number of and reasons for cancelled procedures were reviewed by the senior management team. Following a review, action plans were implemented to address the reasons for cancellations in order to reduce their frequency.
- Systems were in place to manage flow through the centre. Following the pre-admission visit in the outpatients department, a planned admission date was confirmed that same day or shortly after by letter, following discussions with the patient as to the most suitable date. The length of waiting time varied dependant on the consultant and the procedure. We observed the flow of patients to be well managed without delays.
- When patients arrived at the centre for admission, they were greeted by the reception and admission staff were notified of their arrival. They were then escorted by a health care assistant to the admission bays where they were advised on their procedure and what would be happening throughout their admission.
- Due to the elective nature of the admissions and type of patients admitted, duration of stay was one day unless patients required a longer period of recovery, in which case they would be transferred to the inpatient facility at Bristol or to a local acute treatment centre.
- Patients told us that they had been admitted and treated quickly and had not been left waiting for long periods. They told us that they had been taken to the admission bays and then to theatre approximately an hour later. They were then taken to the post-anaesthetic recovery unit following surgery and had been visited by their consultant and advised on their discharge and follow-up care arrangements less than an hour later.
- Discharge planning was considered at pre-admission and at each stage along the patient's pathway. Nursing staff liaised with families and carers on admission to check there was suitable care available before treatment started. Any follow up appointments were arranged for the outpatients department and as the patient's notes were held electronically they were accessible.
- On discharge each patient's GP was sent a letter through the post detailing the treatment provided.

Meeting people's individual needs

- Patients' individual needs were being met by the treatment centre. Patients told us they were well informed about their treatment prior to admission and that staff had provided further information when needed. On discharge further information was provided to patients. This included their discharge letter and contact details for the 24 hour helpline. They were also provided with information on the medication they were discharged with.
- Staff completed assessments of patients' needs and preferences relating to their care and treatment at the pre-admission clinic. The assessment was completed by a registered nurse, who recognised and included emotional, religious, spiritual, physical, cultural and social needs as well as preferences and choices reflecting privacy, dignity, sexuality and disability.
- Care planning was arranged to take into consideration specific issues relevant to certain groups of people, for example patients living with dementia, diabetes and ethnic minority groups. Staff informed us that patients living with dementia were identified at the pre-admission appointment and all staff were made aware if a patient had needs associated with their dementia. Staff also confirmed that patients with diabetes were always put first on the list for surgery to avoid any complications associated with nutritional needs. Any issues with treatment were discussed with the patient and any adjustments were implemented to accommodate specific needs. For example, the centre arranged for a patient to be accompanied to theatre by their mother, as they had anxiety issues related to their learning difficulties. This was done to reduce the patient's distress and anxiety.
- Staff told us that patients' needs were reviewed regularly throughout care and treatment which involved patient-centred discharge planning, with packages of care put in place as required. They stated that this included transfer to other locations by ambulance if required.

- The centre had a formalised care bundle for patients living with dementia which was accessible to all staff. A care bundle is a structured way of improving the processes of care and patient outcomes. This took the form of a flow chart which set out the duration of a pre-assessment clinic should be increased if complex needs were evident and to allow appropriate time to assess the patient. A complete dementia care risk assessment was completed. This included risk assessments for falls, venous thromboembolism and nutrition. Further information was obtained from the patients' GPs, for example to check if the patient had attended a memory clinic or if capacity had been assessed, checking what arrangements were in place, for example, if family/solicitor have "lasting power of attorney".
- The patient's carer was asked to complete a carer assessment document and asked to note which behaviours demonstrate stress in the patient. Staff assessed the family/carer involvement with care in treatment centre and arranged for the carer to stay if willing and arranged suitable staffing cover to monitor the patient. Staff ensured that carer/family were given discharge advice information and had back up support as well as making sure that effective discharge plans were in place to allow for psychological and physical needs.
- When patients were identified as living with dementia, staff told us that any issues were discussed with patients' families and/or carers to determine whether additional requirements or measures were needed. Staff told us there was no dementia champion within the treatment centre and there was no formalised training for caring for patients living with dementia or patients with learning disabilities.
- Staff told us that they had access to an external interpreting service which they could call and arrange support for patients who did not speak English. The service was provided in person and arranged at the earliest opportunity. Staff confirmed that they would never ask family members to interpret for them. The centre also had access to sign language interpreters and in the waiting area, patient information leaflets were available in braille, Bengali and Arabic.
- The centre had a chaperoning policy which all staff had access to. Patients told us that they had been offered a chaperone when attending consultations.
- There were some aspects of the treatment centre environment that were not well designed to meet the needs of patients with visual impairment. This was because some of the floors, which patients used, were shiny, similar colours were used for flooring, doors and door frames, labels identifying exit buttons were not well positioned and did not use easily distinguishable typeface.

Learning from complaints and concerns

- Learning from complaints and concerns received and investigated by the treatment centre did occur with changes being introduced as a direct result**.**
- CQC did not receive any complaints about the centre between April 2015 and March 2016.
- Information on how to make a complaint was available within a leaflet which set out the process and what people should expect. The leaflets were available in the waiting area at reception. Information was also set out in a patient guide, which was sent to all patients and identified how a complaint could be raised and how it would be managed.
- Patients could make a complaints in a number of ways; they could do so verbally, providing feedback during ward rounds, use electronic patient feedback devices, feedback cards, the treatment centre's complaint process, social media, Care UK website, NHS choices and Healthwatch.
- The treatment centre received nine complaints in the periods April 2015 to March 2016, of which we reviewed five. None of the complaints were referred to the Ombudsman or the Independent Healthcare Sector Complaints Adjudications Service (ISCAS) indicating they had been satisfactorily resolved. The investigations of patient complaints were of a high quality and there were no trends or themes.
- A complaints policy was in place and accessible to all staff. The treatment centre director and registered manager were responsible for overseeing the management of complaints. They were responsible for ensuring appropriately qualified staff investigated issues raised. This included the governance manager, and where indicated, the head of nursing, medical director, heads of department and any staff named and involved in the complaint allegation. It was the registered manager's responsibility to ensure issues with practice at the centre was addressed.

- The personal assistant to the registered manager, supported by the governance manager, was responsible for the day to day operational and administrative management of the complaints process.
- Complaints were recorded on an electronic incident reporting system and reviewed by the clinical governance manager to identify trends or themes. All complaints were tracked, trended and analysed against specific specialities and departments on the incident reporting system. The information was used within the clinical governance report to ensure appropriate actions were taken, improvements made and monitored.
- If a manager was unable to resolve any issues then the complaint was escalated to a senior manager on site.
- When a formal complaint was received the treatment centre director decided who should investigate the complaint. Following the investigation a formal response letter was drafted and reviewed by the clinical governance manager to ensure it addressed all of the patient's issues. The letter was reviewed by the medical director or head of nursing. A final review by the treatment centre director took place before being signed off, once assured that all the concerns were addressed.
- When responding to the complainant, the registered manager explained how the decision had been reached and whether the complaint was upheld or not. The complainant was asked to contact the treatment centre if they had any further questions.
- Patients were offered the opportunity to meet with members of the management team but were asked beforehand, if they would like the consultant in question to be present.
- In the complaints records we reviewed we noted an outcome for each issue and when appropriate a letter of apology had been sent. A timescale was recorded for each response and all were within acceptable time limits. There was a process for complaints to be resolved independently if the complainant felt it had not been addressed by the treatment centre.
- The clinical governance manager ensured that the implementation of plans was monitored to ensure changes were effective with key themes discussed with staff to improve the quality of service delivered.
- Staff stated that incidents and complaints were treated seriously and appropriate action was taken both internally and externally, with lessons shared and processes reviewed. For example, a patient had undergone a dental extraction but some of their tooth had remained in situ resulting in an infection. The patient made a complaint as they felt the risk had not been explained to them before surgery. As a result of the investigation, learning from the complaint was shared as they had identified the need to explain all aspects this type of procedure to patients to allow them to make informed decisions regarding their treatment especially given the frequency tooth extractions were performed at the centre.
- Compliments and complaints, including any relating to complications were discussed at departmental meetings, clinical head of department meetings, senior management team meetings and monthly clinical governance meetings.

Are surgery services well-led?

Good

We rated surgical services as good for well led because:

- The vision and objectives for the service were evident and understood by most of the staff.
- There were clear governance processes in place to monitor the service provided.
- Leadership at each level was seen to be visible, approachable and responsive. Staff had confidence at each level.

However,

- The centre's risk register was not in a format which made it easily readable or useable and it included outdated risks.

Vision and strategy for this this core service

- The Care UK vision was to be the UK's leading independent provider for NHS elective care and to be the partner of choice for NHS commissioners, trusted to deliver the right care in the right place at the right time. Part of this vision was to differentiate themselves by the quality of services, ensuring innovative and customer focused care. Care UK described their values as: "our customers are at the heart of everything we do, every one of us makes a difference and together we make things better"

- The vision was supported by a set of values: “to provide care and treatment that is appropriate, meet patients’ needs and reflects individual preferences and choices.”
- The strategy of the centre was to increase patient referrals, range of surgeries carried out at the centre and awareness of the centre in the local and wider community. The way in which this strategy was to be implemented was to engage with the local GPs. The centre was looking at how referrals were being made and updating GPs on what could be carried out at the centre to ensure referrals were not rejected inappropriately. The medical and treatment centre director met regularly with the CCGs to generate more referrals. The centre was organising an open day for visitors which would include tours of the whole centre, including the theatres, PACU, endoscopy suite and consulting rooms. Senior staff stated that the strategy was on going and felt confident that it would yield results.
- Ward and theatre staff had not been engaged in the development of the vision. Most staff were aware of some of the values and vision. However, only a few were able to say what the strategy of the centre was.
- The recent building work at the centre had been designed to facilitate future accreditation with the Joint Advisory Group which would in turn encourage referrals to the treatment centre.

Governance, risk management and quality measurement for this core service

- There were effective governance arrangements which did provide assurance of safety and quality but there were areas that needed improvement, specifically relating to the centre's risk register.
- The management team for the treatment centre was the senior management team consisting of the treatment centre director, medical director, head of nursing and clinical services and the operations manager. The centre had a clinical governance policy which was being followed.
- As the registered manager for the centre, the treatment centre director was responsible for receiving reports on clinical governance from the head of nursing and clinical services and the clinical governance and clinical effectiveness manager each month. The reports were generated from the electronic patient records and electronic incident reporting systems to highlight the key performance indicators. As well as this the treatment centre director was responsible for reviewing reports on patient feedback which were provided by each department on a monthly basis. They also attended monthly clinical governance meetings and joint service review meetings with commissioners.
- The medical director was responsible for reviewing the monthly clinical governance reports and setting out the agenda and detail for the monthly clinical governance meetings. Part of their role was to set the clinical speciality meetings, suggest suitable case studies and topics of interest as well as chairing the morbidity and mortality meetings, which took place bi-monthly.
- Bi-monthly surgical specialty team meetings took place which reviewed surgical procedures and practice, discussed departmental issues, incidents, complaints, audit results and clinical performance. The medical director and representatives from each surgical speciality attended these meetings. Any learning or updates from the meeting were shared and the minutes were circulated by email.
- The head of nursing and clinical services also reviewed the monthly clinical governance reports and contributed to the agenda with topics of interest for the clinical governance meeting. Part of the role included attendance at the Care UK strategic governance meetings and feedback of actions to be taken by the heads of department. They were also the chair of the patient forum group which met quarterly, reviewing the patient experience and service user comments.
- Clinical governance meetings took place every month with all the senior management in attendance. The clinical lead, infection control lead, health and safety lead and clinical governance manager, clinical effectiveness managers, two clinical staff members and non-clinical staff also attended. At the time of the meetings clinical activity was cancelled so all staff could attend. Regional meetings with other Care UK treatment centres also took place to share learning.
- We reviewed clinical governance minutes and saw the agenda included infection control, incidents, complaints, patient experience results, shared learning, updates on policies, standard operating procedures and NICE guidance, PROMs and review of the risk register. During the meetings attendees also reviewed VTE policy and clinical effectiveness. The key sources of information for governance meetings were the incident

reports, the risk registers, staff surveys, feedback from professional development, clinical audit reports, compliments and complaints and patient experience information.

- As part of the quality assurance process the treatment centre and medical director provided detailed monthly updates to the governance manager for Care UK and the secondary care managing director at regular meetings. At the meetings the key performance indicators, incidents, concerns, outcomes and finances were discussed. The centre was able to generate reports which were sent to the central governance team level, when applicable, and would also receive reports to monitor performance against other Care UK centres. Any concerns or issues were discussed and actions taken to address them. As a continuation of this process the medical director provided a quarterly report to the CCGs.
- Any performance issues relating to the medical staff were monitored by the medical director as detailed reports were produced on any and all surgeries performed using the electronic patient records system, audit results and appraisals. If any performance issues arose the medical director could address this with a consultant directly using reliable data and statistics. The issues were addressed and actions implemented to improve performance, including additional training and performance management procedures. The clinical lead monitored the performance of all nursing and allied health professionals at the centre with issues closely monitored and addressed in the same way.
- The theatre, post-anaesthetic recovery unit and endoscopy suite held monthly departmental meetings, which all staff were encouraged to attend. We saw minutes for all departments and these included discussions about areas of risk, outcomes, privacy and dignity issues, infections control and NICE guidance.
- When we spoke with all levels of staff, they demonstrated understanding of their responsibilities and they were able to explain how learning outcomes were shared, how trends were identified and how and when issues needed to be escalated. The majority of staff were aware of what they were accountable for within their roles and knew who to approach with any concerns or issues about the service.
- There was a clinical and internal audit programme which monitored quality and system effectiveness. The results of the audits were discussed regularly at numerous meetings with actions taken to address performance issues. The results of the audits within the centre were positive but discussions took place and actions were taken to maintain high performance.
- Local risks were identified using a centre-wide risk register. The risk register was reviewed at monthly health and safety meetings attending by the Hospital Director, senior management team, clinical governance and health and safety managers and all department health and safety representatives.
- We saw entries on the risk register that had been addressed but remained open as a risk. We reviewed clinical governance meeting minutes where the risk register was part of the agenda but discussions appeared limited and were not particularly detailed. It was not clear, upon review, whether risks were discussed at length.
- We were told that the current format of the risk register was under review and the clinical governance manager was looking at ways to improve it. In addition, we were informed that the location of the scrub sink was to be risk assessed again and put on the risk register.

Leadership / culture of service related to this core service

- Staff spoke positively about the leadership and culture within the centre. The leadership at local level for surgery comprised of the clinical lead, theatre lead, endoscopy lead and PACU lead. The medical director had oversight of the surgical services and any issues were escalated to the clinical director for Care UK. The centre operated a rota for the senior management team with responsibility being split between hospital director, head of nursing and clinical services, operations manager, clinical governance manager, and relevant heads of department.
- At a departmental level each lead reported monthly to the clinical lead on matters which included audits, staffing, incidents, complaints and concerns. If the clinical lead was absent they appointed one of the leads to take over their responsibilities until their return. We saw that these arrangements had been formalised in a standard operating procedure and were told by staff that it was always adhered to.
- The centre had a Duty Manager rota and a standard operating procedure governing this. We observed the

procedure being adhered to and senior staff told us that there was always a Duty Manager on site. In cases of delayed attendance of the Duty Manager, the clinical led would take over operational duties.

- Staff told us that they felt the divisional and senior management team were visible and approachable. The clinical lead felt that the staff at the centre worked well as a team and could raise any concerns with her, which was confirmed by what staff told us.
- Should performance management be required, this was undertaken by the clinical lead or medical director depending on the staff member involved. Both leads confirmed that they would support the member of staff involved in any way they could.
- Staff told us that they felt respected and valued with opportunities for training and development available. The staff demonstrated that they were all working together and wanted to deliver care to patients that was both safe and of high quality. Staff told us they were encouraged to be open and honest with patients.
- Staff within theatres and the PACU told us that they felt able to challenge a consultant if they felt something had been missed. They stated that this enabled better working within departments as there was no hierarchy and they could speak freely.

Staff engagement

- The centre held a staff forum group every three to four months, where issues and concerns were raised and discussed. There was also a staff feedback box to allow staff to raise concerns anonymously. Staff told us that they were encouraged and felt able to raise concerns with senior management.
- An annual staff survey provided staff with an opportunity to provide feedback. Results were collated, analysed externally and shared with staff, with action plans implemented across all departments, although the response rate from staff was low. We saw evidence that an action plan had been created to address some of the issues highlighted in the responses, including how to increase integration of the teams at the centre and at the inpatient facility at Bristol and sharing of information from meetings.
- Good practice was rewarded on a monthly basis through a staff recognition scheme, where staff could nominate individuals who had demonstrated outstanding practice.

Public engagement

- The 'You said, we did' scheme in response to patient feedback was used and discussed at clinical governance meetings. We saw evidence that improvements had been made as a result, for example a patient asked if arrangements could be made for communion on the post-anaesthetic recovery unit, so the centre arranged for a local chaplain to visit the patient.
- There was a patient forum group, which was chaired by the head of nursing and clinical services. The group met quarterly with senior management to help develop and improve services and was attended by patient representatives, the treatment centre director and other staff members. Forum members also attended monthly quality assurance governance meetings which started with a patient story to share patient experiences of the service. Patient feedback and comments were discussed to see if improvements to the centre could be made.
- The treatment centre had held an open day in 2015 to encourage patient and public involvement within the centre. They also planned to hold another in October 2016.
- Real time feedback was obtained using hand held devices with a touch screens and was offered to every patent at each point of service. Weekly and monthly reports were generated by an external supplier and showed feedback for each survey carried out per device, showing answer breakdown per question, response volume trend and question score. The reports were used by managers to plan actions to improve services. Results were also discussed and benchmarked at clinical governance meetings locally and Care UK.

Innovation, improvement and sustainability

- The treatment centre supported innovation, improvement and sustainability by working with local acute treatment centres. They had invited consultants working at local acute trust to attend the centre to perform procedures in order to promote further learning among employed consultants.
- A programme had been introduced at the centre to increase efficiency within the surgical department. The programme was introduced to monitor utilisation of endoscopy and theatre sessions, addressing late starts, early finishes and turnaround times.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The Devizes NHS Treatment centre housed four consulting rooms to carry out consultations for new and follow up patients. These rooms were equipped to perform minor procedures: naso-endoscopies, ear suctioning, biometry and 'Yag' laser and haemorrhoid banding. The outpatient department offered appointments in various specialties. These included Oral surgery 16.4%, Ear Nose and Throat (ENT) 11.9%,Ophthalmology 11.8%, General surgery 11.2%, Orthopaedic (major and minor) 13%, Gynaecology 2.8%, and Urology 0.8%.

The radiology department provided x-ray and ultrasound, and dental imaging. There was one X-ray room including a dental imaging machine and one ultrasound room. Diagnostic imaging referrals made up 32% of all outpatient attendances

During the period April 2015 to March 2016 there were 13,520 outpatient attendances, all of these patients were funded by the NHS. Fifty seven of these outpatients were young people aged 16-18 years and 2,226 were aged over 75 years.

All treatment at the treatment centre was consultant led. All consultants were employed on either bank or substantive contracts. All outpatient clinics were staffed by a combination of doctors, nurses and healthcare assistants. All radiography and sonography examinations were undertaken by qualified staff.

During our inspection of the outpatients and diagnostic services, we visited the outpatients and diagnostics clinic areas, observed four clinic consultations, looked at four individual patient records and spoke with 22 staff, six patients, three carers and two members of the patient forum and reviewed 16 comments cards.

Summary of findings

We rated outpatients and diagnostic imaging as good overall because:

- Incidents were reported and thoroughly investigated, learning was shared and trends monitored and reviewed.
- The outpatient department environment was clean and staff adhered to infection control protocols. There had been no incidents of treatment centre acquired infections during the twelve months preceding our inspection.
- There were safe systems for the management of medicines. These were monitored closely by the pharmacy team and discrepancies were fed into the governance processes.
- There was adequate nursing and medical staff as determined by the use of a safe staffing tool.
- Individual patient care records were comprehensive, legible and complete. Records were stored securely.
- There was good compliance with mandatory training including safeguarding adults and children. Safeguarding concerns were reported by staff and were investigated by the safeguarding lead.
- Staff assessed and responded to patient risks. The patient experience nurse followed up all patients by telephone after their outpatient appointment and prior to their surgery. This nurse ensured that all

Good

Outpatients and diagnostic imaging

investigations and screenings were completed, and checked that patients understood and were compliant with pre-surgery guidance such as changes to medication routines.

- Outpatient department teams reviewed assessment and treatment protocols in line with guidance published by the National Institute for Health and Care Excellence.
- Staff in the diagnostics service followed best practice guidelines including use of local rules and diagnostic reference levels to aid optimisation in medical exposures.
- The outpatient service participated in a comprehensive audit programme and submitted patient reported outcome measures for groin hernia repair and varicose vein operations.
- All staff had an up to date appraisal. Staff were encouraged to attend external training. The appointment process for medical staff was rigorous and assured.
- There were good interdisciplinary relationships within the treatment centre. Clear referral criteria were available for referring health professionals.
- All relevant information needed for patient care was accessible to staff.
- The majority of patients in outpatients and diagnostics were extremely likely or likely to recommend the service to others.
- Staff showed an encouraging, supportive and sensitive approach toward patients and used communication skills to provide reassurance to patients who needed emotional support.
- Patients were given a choice of locations for their outpatient appointment. Theatre schedules were prepared three months in advance to allow outpatients a choice of date for their surgery.
- Referral to treatment times were within 12 weeks. Radiology images were reported on within 24 hours.
- Multidisciplinary meetings were held to discuss the requirements of patients with additional needs such as a learning disability. Reasonable adjustments were made such as encouraging carers to attend the outpatient appointment and booking double appointment slots.
- The registered sick children's nurse ensured that the specific requirements of patients aged 16-18 years were identified and addressed prior to their surgery date.
- Complaints were investigated thoroughly and learning was shared across teams.
- Governance systems were in place to ensure safe care for patients. There were reliable systems for staff to identify and escalate risk
- In the monthly governance meeting, senior staff discussed and reviewed key performance data and updates to clinical protocols and guidelines.
- There was a comprehensive programme of audit. Actions were taken to make improvements as a result of audits.
- The treatment centre was moving towards meeting the workforce race equality standards. An electronic database had been set up to record personal details volunteered by staff regarding ethnic background.
- Staff told us they felt supported by managers and their peers
- There was good engagement with patients and with staff.

However

- Not all staff prioritised the requirement to keep fire exits clear. We saw a supplies cage obstructing a fire exit on two separate occasions.
- Not all staff took action to minimise risks to the privacy of patients during outpatient consultations.
- The percentage of patients who did not attend for their appointment was high for dental first appointments and follow up appointments.
- Some aspects of the clinic environment were not well designed to meet the needs of patients with visual impairment.

Good

Outpatients and diagnostic imaging

- The 2016 staff survey identified areas for improvement.
- On the risk register, details of the controls and gaps in controls were not consistently well defined.
- The risk register was not specific to core services and contained both open and closed risks. This meant that open risks specific to the outpatient department were less easily located on the risk register.

Are outpatients and diagnostic imaging services safe?

Good

We rated outpatients and diagnostic imaging as good for safety because:

- Staff reported incidents. These incidents were thoroughly investigated, staff were given feedback and learning was shared within the treatment centre teams and across Care UK locations where appropriate.
- Trends from incidents were monitored and escalated through the governance system.
- In radiology, staff understood their role in reporting incidents of exposures much greater than intended. There had been no incidents of this kind in the twelve months preceding our inspection.
- Staff ensured that the outpatient environment and equipment were kept clean. Procedures were in place to prevent the spread of infection and these were regularly audited.
- Outpatients and diagnostic equipment was regularly serviced. Action had been taken to rectify faulty equipment.
- There were safe systems for the management of medicines. These were monitored closely by the pharmacy team and discrepancies were fed into the governance processes.
- There was adequate nursing and medical staff as determined by the use of a safe staffing tool.
- Individual patient care records were comprehensive, legible and complete. Records were stored securely.
- There were arrangements in place to safeguard adults and children from abuse. Concerns were reported by staff and were investigated by the safeguarding lead.
- There was good compliance with mandatory training including safeguarding adults and children.
- Staff assessed and responded to patient risks. The patient experience nurse followed up all patients by telephone after their outpatient appointment and prior to their surgery. This nurse ensured that all investigations and screenings were completed, and checked that patients understood and were compliant with pre-surgery guidance such as changes to medication routines.

However

- Not all staff prioritised the requirement to keep fire exits clear. We saw a supplies cage obstructing a fire exit on two separate occasions.

Incidents

- Staff understood and carried out their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. When things went wrong in the outpatients and diagnostics department, thorough investigations were carried out and lessons were learnt. For example, several incidents had been reported regarding the ultrasound machine overheating and subsequently switching off during clinics. This was investigated, a fan was used to maintain a cool temperature and bookings were managed to allow time for staff to switch off the machine between patients.
- The management team ensured that the processes of incident reporting and investigation of incidents was followed through consistently. When staff members reported an incident, they had the option to tick if they wished to receive feedback. The head of nursing ensured that this loop was consistently adhered to. The governance manager approved action plans. The health and safety lead monitored any trends arising from incidents and produced a monthly report to the clinical governance team. Some incidents triggered an email to the director of nursing and quality at head office and the quality and governance manager at head office, depending on the severity of the incident reported. We saw that investigations were discussed at heads of department meetings. Teams ensured that each incident was allocated a reviewer and reviews included learning points.
- There were examples of incidents where lessons were shared to ensure action was taken to improve safety beyond the affected team or service. In the diagnostics service, a sonographer told us about an incident that had resulted in personal learning and a change in practice for the individual sonographer, as well as shared learning for the department and other diagnostic teams within Care UK.
- Care UK used a tool to share learning across locations. For example a treatment centre in another location had used an incorrectly diluted eye solution during a procedure. Procedures were amended following the incident and these learning points disseminated to all Care UK sites. Staff at the treatment centre were aware of this learning. At the monthly governance meeting, teams had discussed an information governance incident that had occurred in the radiology department of another Care UK site. This learning was detailed in the minutes for staff at Devizes to access.
- The imaging service had a reliable system that ensured exposures that were 'much greater than intended' were notified to the Care Quality Commission under Ionising Radiation (Medical Exposure) Regulations 2000 (amended 2006) requirements and that radiation incidents were fed into the risk management process. There had been no occurrence of such incidents during the twelve months preceding our inspection.
- The notes presented at the monthly governance meeting showed that 22 patient safety alerts cascaded via the central alerting system had been considered that month but none were identified as relevant to the outpatients or diagnostics service.
- Consultants in outpatients confirmed they were involved in monthly mortality and morbidity review meetings where patient outcomes were discussed and learning was shared.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. In the 12 months preceding our inspection, there had been no incidents within the outpatients and diagnostic service that required official exercise of the duty of candour. Staff were able to demonstrate a good understanding of the duty of candour and their responsibilities.

Cleanliness, infection control and hygiene

- Systems and processes were in place to protect people and reduce the risk of cross infection. The outpatients and diagnostics environment was visibly clean. Staff explained how standards of cleanliness and hygiene were maintained. For example, staff showed us how equipment in the ophthalmology clinic was wiped down after every use and cleaned thoroughly at the end of every clinic. We observed a member of staff cleaning the endoscope using the Tristel wipe system. This system

included completion of a record book to ensure an audit trail of patient identity linked to endoscope and date used. All endoscopes were sent to the endoscopy unit at the end of the day to be checked for leaks and for thorough cleaning. The sonography equipment was cleaned using the Tristel three wipe system. Cleaning was documented and traceable using patient identification stickers.

- We saw evidence that cleanliness and hygiene checks were regularly carried out in all outpatient areas. However, access around the store room was restricted due to clutter and several boxes were stored on the floor making the area difficult to keep clean. Some clinical supplies such as infusion solutions were stored just below ceiling height on solid shelves. Dust had accumulated on and behind these items and this increased the risk of contamination of the clinical environment when items were opened. . There was no schedule for cleaning the shelves and no record of when the store room was last cleaned. We saw that this had been identified during a health and safety meeting in April 2016. At the time of our inspection, the cleaning schedules were under review following a reduction in housekeeping staff hours from 40 to 27.5
- Reliable systems were in place to prevent and protect people from a healthcare-associated infection. Registered nurses triaged every referral by telephone and this process identified infection control issues that could be treated prior to patients attending for their outpatient appointment. For example, one-stop dental surgery was cancelled for one patient who had experienced diarrhoea and vomiting in the day preceding their appointment.
- Most of the patients attending the outpatients department did not require screening for methicillin-resistant staphylococcus aureus (MRSA). This was not completed for dental procedures or for eye procedures but the patient was asked if they had been in contact with any potential risk sources. During April to July 2016, an average of 405 patients was screened for MRSA and less than one percent had tested positive. When a patient tested positive for MRSA, the patient experience nurses liaised with the GP to commence treatment. Surgery was postponed until the patient tested negative. Going forward, the team planned to audit the MRSA screening process on a quarterly basis.
- In the event of a patient disclosing a communicable infection during an outpatient consultation, staff ensured that the clinic room was deep cleaned prior to being used for subsequent patients.
- Staff took precautions to prevent the spread of infection. Personal protective equipment was available in all clinic rooms. We saw that staff used effective handwashing techniques. Hand gel dispensers were available in consulting rooms and at entrances to corridors and waiting rooms. In June 2016, hand hygiene audits scored 100%.
- There had been no occurrences of treatment centre acquired infection during the 12 months preceding our inspection.
- There were regular audits of cleanliness, infection control and hygiene. These included audits of a variety of themes such as: staff training, governance systems; environmental audits such as sanitary areas, dirty and clean utilities, store room, domestic water coolers, linen, equipment such as sharps handling, personal protective equipment, waste management, transportation of specimens, peripheral vascular devices; aseptic technique including hand hygiene, urinary catheter care; isolation, standard precautions; and antibiotic stewardship. The results of the audits were between 87% and 100%. These audits were reviewed at monthly infection control meetings attended by infection control link nurse from each department. Where any non-compliance was identified, action plans were in place to ensure future compliance.

Environment and equipment

- Facilities and premises were designed in a way that kept people safe. For example, the waiting room was fully visible to the staff behind the reception desk. There were emergency call bells in all consulting rooms and changing areas for patients. However, we noted that in the x-ray room the emergency call button was situated behind a large immobile scanner and this was difficult to access.
- Equipment was regularly and adequately maintained to keep people safe. All equipment in the outpatients department was booked for servicing two weeks after the date of our inspection. Fire extinguishers in the outpatients department were recently checked for safety and all electrical testing had been completed for portable electrical equipment.

Good

Outpatients and diagnostic imaging

- Safeguards were in place to ensure safe use of laser equipment in the outpatients department. The laser protection supervisor understood their role and responsibilities. Local rules were in place for laser treatment. The handbook for laser protection supervisors contained a list of registered users. All equipment had been serviced regularly. The medical physics expert advice was obtained form an external company who attended once a year to recalibrate equipment. The laser protection advisor visited once a year and was available for advice on the telephone, if required. A laser equipment safety audit was completed in October 2015 with no issues identified.
- There were safe systems for managing waste and clinical specimens. We saw that sharps bins were correctly filled, labelled and securely fastened.
- Resuscitation equipment was available at the treatment centre but was not located in the outpatients department. The management team had assessed this risk as acceptable due to the size of the location and the availability of portable resuscitation masks in outpatient reception. The resuscitation equipment was checked daily.
- The teams in outpatients had made improvements to staff compliance with cleaning protocols for equipment. In May 2016 an audit of equipment in outpatients and diagnostics scored 87%. Non-compliance issues related to routine cleaning of equipment for every patient and the decontamination of monitoring leads/straps between patients. In June 2016 this audit scored 100%.
- The design of furniture and furnishings was compliant with infection control best practice. For example, all curtains were paper and were replaced every six months. Armchairs and examination couches were wipeable.
- Not all staff prioritised the requirement to keep fire exits clear. The outpatient stores were located in an outside metal container accessed via the fire escape (all one level). At the time of our announced inspection and again during the unannounced inspection the fire exit was obstructed with a large cage of supplies. Managers told us that a new system for delivery of supplies was planned but not yet implemented.
- Staff were aware of correct procedures to maintain the safety of equipment on a day to day basis. For example the sonographer completed a check of all equipment used in sonography every two weeks. The sonographer was aware which equipment was more at risk of malfunction and ensured new parts were ordered well in advance. An air conditioning unit had been ordered to minimise the risk of this machinery overheating.
- The outpatient team ensured that outpatient equipment was producing accurate results. For example, healthcare assistants calibrated the ophthalmology eye equipment before the start of every clinic. Staff told us about an occurrence when they had noticed the echocardiogram machine was producing identical data for every patient during the course of a clinic. A fault with the machine was detected and subsequently resolved.
- The head of radiography ensured that radiology equipment produced images of suitable quality. In early 2016 the radiology service at Devizes was contacted by the local acute trust because the quality of images received via the electronic portal had deteriorated. The chest x-ray service at the treatment centre was suspended whilst the radiography manager investigated this issue. The head of radiography visited the local acute trust to understand the problem and liaised with the manufacturer, who visited the site to check the equipment and make adjustments.

Medicines

- Arrangements for medicines kept people safe. There were standard operating procedures in place for obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of medicines in the outpatients department. Medicines were stored in a refrigerator and refrigerator temperatures were checked daily. The outpatient departments we visited did not administer controlled drugs. FP10's were stored securely.
- When doctors prescribed antibiotics for patients, there were systems in place to provide assurance that this was done in accordance with local antibiotic formularies as recommended in guidelines published by the National Institute of Health and Care Excellence.
- All relevant information about a patient's medication was recorded at pre-operative assessment using the electronic records system. In addition there was a scanned copy of the patient's referral letter which highlighted any medication or allergies. The patient experience nurse looked through the patient's medical records to check the medications of all outpatients. If

patients were taking any medicines that were contraindicated for surgery, the patient experience nurse advised them regarding the protocols for stopping the medication prior to their date of surgery.

- The multi-disciplinary team in outpatients were given support to ensure the safe prescription of medicines. The pharmacy team highlighted the importance of recording allergies at mortality and morbidity review meetings, governance meetings, medicines management meetings and through audit of pharmacy interventions. The medical director provided feedback to prescribers and anaesthetists regarding incomplete prescriptions. The pharmacy team provided education and tools to raise staff awareness of risks associated with polypharmacy.
- The treatment centre produced a pharmacy dashboard that was presented to governance and medicines management meetings on a monthly basis. This included data regarding the occasions when pharmacists provided feedback to prescribers regarding errors on prescriptions, plus complaints and incidents reported. The number of occasions when pharmacists provided feedback to prescribers regarding errors on prescriptions as a percentage of activity ranged from three to eight percent during April 2015 to March 2016.

Records

- Individual patient care records were easily accessible during consultations. Outpatients and diagnostics services used a combination of paper and electronic records. For example, paper copies of referral letters and patient questionnaires were stored in hard copy format. Discussions during the outpatient consultations and the pre-operative nurse consultations were recorded directly onto the electronic patient record. Prior to surgery, the patients' paper records and electronic records were reviewed by the patient experience nurse and then paper records were scanned onto the electronic record.
- Staff protected the confidentiality of patients' individual care records. Paper copies of individual patient records were stored securely in a store room behind the reception desk. There was always a member of staff in this area. Some paper copies of patient records were stored in a cupboard inside the patient experience nurse's office which was accessible only with a security access fob. Staff accessed the electronic record system using passwords that were regularly changed. An electronic audit trail was accessible that allowed any breaches of information governance to be investigated.
- We looked at four patient records. These were comprehensive, legible and complete. There was a documentation audit that included patient records in April 2016. This scored 99%.

Safeguarding adults and children

- There were arrangements in place to safeguard adults and children from abuse that reflected the relevant legislation and local requirements. Staff understood their responsibilities to report safeguarding concerns. Minutes of meetings of the safeguarding committee confirmed that staff were raising appropriate safeguarding concerns and these were being investigated by the safeguarding lead.
- These systems were monitored and improved when required. For example in May 2016 the safeguarding committee identified that the triage of patients under the age of eighteen needed more focussed attention. A new pathway was introduced whereby every patient under eighteen was reviewed by the registered special children's nurse (RSCN). If the young person presented with additional requirements the RSCN then convened a multidisciplinary meeting to discuss and arrange reasonable adjustments. Compliance against the standard operating procedure for young adult was reviewed in August 2016. This review identified that the triage process was not being followed consistently, that multidisciplinary meetings were not documented and that no specific letter for young adults was in use. Some actions were completed to rectify this non-compliance, such as the introduction of a specific appointment letter for young adults, the triage of all referrals for young adults by the registered sick children's nurse, and the introduction of a bi-monthly meeting to discuss referrals received for young adults. Some actions were due for completion after our inspection, such as the revision of the standard operating procedure and the revision of the health assessment to be more focussed on the needs of young adults.
- Staff could access support regarding safeguarding queries. A comprehensive resource folder was available in the outpatients department containing reference materials, pathways and contact points on themes such as domestic violence, female genital mutilation,

trafficking and sexual exploitation. The safeguarding lead was also the clinical lead for the treatment centre and staff felt comfortable to ask them for advice regarding safeguarding concerns.

- Staff were adequately trained to identify safeguarding concerns. In June 2016, staff compliance with face to face and electronic training for level two safeguarding vulnerable adults was 100%. In September 2016, outpatients and diagnostics staff compliance with face to face level three safeguarding children was 94.7% and compliance for e-learning level two safeguarding children was 100%.

Mandatory training

- Staff received regular mandatory training updates. In July 2016, mandatory training compliance for all staff working in the treatment centre was good with an overall compliance of 97.1% against a target of 90%. There was 100% compliance in the following subject areas: fire safety, infection control, duty of candour, medicines management and safeguarding adults, advanced life support , patient consent, preventing vulnerable people and children being drawn into terrorism and clinical governance.; Compliance in other subject areas was as follows: intermediate life support 97.4%; equality and diversity 97.1%; mental capacity act and deprivation of liberty standards 96.6%; information governance 94.7%; basic life support 94.3%; moving and handling 94.3%; safeguarding children 86%.
- Staff told us there was adequate time to complete their mandatory training via e-learning during the monthly governance days.

Assessing and responding to patient risk

- There were systems in place to ensure that individual patient risks were identified and managed safely. All patient referrals to the treatment centre were received via the electronic referral system and triaged by registered nurses based at the inpatient facility in Bristol. These nurses used 'safe patient acceptance criteria' to ensure only those patients with needs that could be safely met by the treatment centre were accepted.
- A referral guide was available for health professionals. This guide explained the referral criteria and outlined the patient pathway for potential referrers to the service. The patient safety exclusion criteria were listed as: patients under 16 years of age, patients under 18 years who weighed less than 40 kilograms, patients with possible or confirmed diagnosis of cancer, clinical emergencies, patients with severe systemic disease with functional impairment, patients who were pregnant and patients with a body mass index of more than 42 for general/regional anaesthesia subject to individual assessment or 45 for local anaesthesia.
- Systems were in place to alert the team to individual patient risks. Any staff member could highlight an alert on the electronic patient record using the free text box which was then visible to all staff accessing the record before, during and after surgery. The patient experience nurse ensured that specific risks were identified, managed and communicated to the multidisciplinary team prior to the patient attending for their surgery. For example, this nurse had identified a risk for a patient who suffered from sleep apnoea and was planning to have sedation during a dental procedure. The nurse communicated this risk to the consultant and identified it on the electronic record using an alert to ensure the theatre team were aware and the anaesthetist was able to make necessary adjustments.
- Safeguards were in place to ensure that all known risks were mitigated prior to the patient's surgery. The patient experience team were responsible for ensuring that the patient understood and was following pre-surgery guidelines such as warfarin management and also checked to ensure that the patient's general health and social circumstances had not changed since their pre-operative assessment. This team also ensured that all investigations were completed prior to the patient's surgery date. The patient experience nurse telephoned the patient five days before their surgery to check this information and to advise the patient accordingly. Surgery dates were rearranged if necessary.
- Risk assessments in outpatients were completed as appropriate to the surgery being carried out. For example, falls assessments were completed for joint surgery but not for dental procedures. Nutritional screening was completed for patients requiring general anaesthetic. The Care UK policy regarding assessment for venous thromboembolism (VTE) excluded several outpatient procedures such as oral surgery or ophthalmic surgery completed under local anaesthesia with or without sedation, gastrointestinal endoscopy, banding of haemorrhoids, vasectomy, hysteroscopic procedures and removal of skin lesions. VTE assessment compliance was 100% during March 2016-May 2016.

Good

Outpatients and diagnostic imaging

- Staff were aware of protocols for managing challenging behaviour in the outpatients and diagnostics department. Reception staff and nursing staff we spoke with were aware of de-escalation techniques that could be used in the event of a situation becoming volatile. An emergency call bell was accessible in all areas. Senior managers were called to address patients concerns at the earliest opportunity, in order to diffuse potential distress to patients and to staff.
- Safeguards were in place to ensure that all known risks were mitigated prior to the patient's diagnostic investigation. When female patients were referred for an x-ray, radiography staff asked them the date of their last period in order to be sure of their pregnancy status before they were exposed to any radiation. We saw evidence that radiography staff declined to carry out imaging for a patient who disclosed she was pregnant during their outpatient consultation.
- Radiology staff followed the Royal College of Radiologists six point check prior to every imaging. This included checking of the patient's name, date of birth, address, the reason for the exposure, the referrer and the justification.
- The imaging service ensured there were arrangements in place to restrict access to radiology areas. There were adequate signs displayed in the radiation department such as warning triangle signs on doorways and light up signs above doors informing people about rooms where radiation exposure was taking place.
- The radiography manager was the designated radiology protection supervisor. The radiation protection advisor was accessible by telephone for providing radiation advice and visited the department once a year to audit procedures.
- The imaging service ensured that X-ray or ultrasound requests were only accepted in accordance with IR(ME)R. The radiology team accepted referrals from GPs, consultants and the radiologist based at the inpatient facility in Bristol and did not accept referrals from non-medical practitioners. The service used a radiological investigations guidelines tool endorsed by the Royal College of radiologists.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times. The treatment centre used a staffing model to identify the appropriate nursing staff requirement for outpatients and diagnostics according to the number of clinics planned and skill mix required for each clinic. For example, staffing of clinics was arranged so that a health care assistant was available to chaperone all patients during their outpatient appointments and during sonography.
- In October 2015 a staffing review was completed to ensure the model fitted with increased demand and change in activity and case mix which identified that outpatients was overstaffed by 1.2 registered nurses and understaffed by 0.4 health care assistants. At the time of our inspection there were 3.2 whole time equivalent registered nurses and 3 whole time equivalent health care assistants working in the outpatient department.
- A bank of staff had been recruited to provide cover for fluctuations in activity. In some instances the bank staff covered long term sick absenteeism through fixed termed contracts. Maternity cover and some long term absences were covered with fixed term contracts. Short notice unplanned absences are covered by overtime, bank, utilising staff from other departments and as a last resort agency staff. During the period January 2016 to March 2016, there were no unfilled shifts in the outpatient department.
- There had been no use of agency staff in outpatients and diagnostics during the 12 months from April 2015 to March 2016. Use of bank nursing staff had varied throughout the same period. This ranged from 0% registered nurses during December, February and March 2016 to 12.9% in June 2015. For health care assistants this ranged from 4.4% during August 2015 to 23.1%% in October 2015.
- Turnover of nursing staffing between April 2015 and March 2016 had averaged 25% for registered nurses and 40% for health care assistants working in the outpatient service. To address staff turnover, there had been a recruitment campaign plus all staff were sent an exit interview questionnaire by email facilitated by an external company. Staff were then offered an additional face to face informal exit interview with the human resources manager.

Medical and other staffing

- There were no consultants engaged under practicing privilege arrangements as all consultants were employed on substantive or bank contracts or were

engaged on a self-employed basis. The self-employed consultants only practiced at the centre if they agreed to follow the centres policies and provided evidence of appropriate skills and registration.

- The vast majority of consultants worked for Care UK directly and so received their appraisal and revalidation through the centre. The medical director was responsible for all revalidation and appraisals of all consultants, employed by Care UK .The self-employed consultants forwarded their revalidation and appraisal documents from their responsible officer to the centre. Responsible officers are individuals who hold responsibility for ensuring consultants have the necessary registration and documentation to provide medical treatment, including carrying out appraisals, revalidation and managing any restrictions on their practice. All consultants practicing at the centre had been revalidated at the time of our inspection.
- There was one radiologist based at the inpatient facility in Bristol who had regular face to face contact with the radiographers in Devizes. This radiologist reported on the images at Devizes on a daily basis.
- The treatment centre reported no concerns with medical staffing in the outpatient service.
- At the time of our inspection, there were 11.9 whole time equivalent medical staff employed at the treatment centre.

Major incident awareness and training

- Teams were prepared to deal with a fire situation. A fire drill was completed in August 2016 by an external company. The report concluded that the situation was managed in a smoothly controlled manner.
- Teams were prepared to deal with a cardiac arrest situation. Throughout the treatment centre, five members of staff were trained in advanced life support and one of these members of staff was always on duty during opening hours. All other staff were trained in basic life support.
- The outpatient and diagnostic teams participated in cardiac arrest drills every two months using a life-size dummy arranged in various scenarios throughout the treatment centre. In the last drill in June 2016, it was noted that outpatient staff did not attend because the alarm was silenced too early. Learning from this drill was shared in the resuscitation committee meeting.
- Staff in radiology knew who to contact in the event of a radiation incident occurring.
- At the time of our inspection the standard operating procedure for dealing with a major incident was under review.

Are outpatients and diagnostic imaging services effective?

We do not currently rate effective for outpatients and diagnostic imaging.

Our findings were:

- The outpatient service reviewed assessment and treatment protocols in line with guidance published by the National Institute for Clinical and health Excellence.
- Staff in outpatients and diagnostic imaging services followed evidence based integrated care pathways and best practice guidelines. The imaging service used local rules and diagnostic reference levels to aid optimisation in medical exposures.
- The outpatient service participated in a comprehensive audit programme and submitted patient reported outcome measures for groin hernia repair and varicose vein operations.
- All staff had an up to date appraisal. Staff were encouraged to attend external training. The appointment process for medical staff was rigorous and assured.
- There were good interdisciplinary relationships within the treatment centre. Clear referral criteria were available for referring health professionals.
- All relevant information needed for patient care was accessible to staff.
- Patients could access a 24 hour advice line if they had concerns following their outpatient appointment.
- There were systems in place to ensure the consent process was thorough and that patients with additional needs were supported to make decisions.
- There was a corporate supervision policy. However, a recent audit had identified some non-compliance with the completion of documentation and reduced staff awareness of the purpose of supervision and the requirement to set targets. An action plan was in place to address this.

Evidence-based care and treatment

Good

Outpatients and diagnostic imaging

- Staff in the outpatient service incorporated relevant guidance and current evidence-based practice to develop how services, care and treatment were delivered.
- The National Institute for Health and Care Excellence (NICE) produce standards for health care based on evidence of best outcomes. In June 2015 the treatment centre had reviewed the NICE quality standards QS3 Venous thromboembolism in adults: reducing the risk in treatment centre. This analysis had identified further action was required relevant to the pre-operative assessment clinic including implementation of the NHS assessment tool, training for staff, updating of the patient information leaflet. Members of the thrombosis committee were collecting evidence regarding use of aspirin for prevention of venous thromboembolism. This would be used to inform discussions with stakeholders regarding future change in policy.
- In August 2016 the treatment centre had reviewed the NICE quality standards QS121 Antimicrobial stewardship. This analysis had identified further action was required by the outpatients team including provision of information to patients regarding self-management and over use of antibiotics plus training for staff regarding the standards. This analysis also highlighted the need to consider innovation in antimicrobial stewardship including e-prescribing, however there were no agreed plans to implement this at the time of our inspection.
- In August 2015 the outpatient service reviewed the NICE clinical guidance NG45 Routine Preoperative Tests for elective surgery. This analysis identified areas of practice that did not conform to these guidelines, such as routine testing all women of child bearing age for pregnancy if their surgery required sedation, routine testing for sickle cell anaemia, routine performance of glycated haemoglobin test for all patients with diabetes, and routine urine tests prior to surgery. Actions identified included review of procedures by the anaesthetists and the surgeon's teams.
- Outpatients nursing staff assessed patients' needs and planned their care in line with evidence-based guidance. The patient experience nurse followed guidelines for the management of medicines and referred to relevant NICE guidelines for the appropriate pre-operative management of patients. For example, the guidelines issued from the diabetic association had recently changed regarding the peri-operative management of oral hypoglycaemic agents.
- Staff in radiology followed best practice guidelines. Exposure charts, local rules, local diagnostic reference levels and the radiology safety checklist were all visible on the notice board within the radiology examination room and were available on the shared computer drive. The imaging service used diagnostic reference levels (DRL's) as an aid to optimisation in medical exposure. Staff were able to locate and explain how they used these as a tool. These levels were regularly audited every two months. Radiographers compared the local audits against national levels. The base levels had been adjusted following advice from the radiation protection advisor during a recent visit.

Pain relief

- Healthcare assistants in outpatients explained how they would escalate concerns regarding patient's pain levels to either the registered nurse or the consultant. When a patient reported high levels of pain, the patient was seen by the consultant and the anaesthetist would complete a face-to-face interview or records review prior to surgery.

Patient outcomes

- In the outpatient service, information about the outcomes of people's care and treatment was routinely collected and monitored for certain conditions. The outpatient service participated in Patient Reported Outcome Measures for groin hernia repair operations and for varicose vein operations. The treatment centre results for groin hernia repair surgery were within the expected range for the last two years, with adjusted health gains for patients slightly better than the England average.
- An audit of radiology services had been completed by the radiology protection advisor in September 2016. This had highlighted some recommendations that included: minor changes to the IRMER procedures, minor changes to the quality assurance procedures for radiology equipment and a professional development course for the radiology protection supervisor to attend.

- The radiation protection supervisor completed dose audits every three months and levels for all staff had been below the national averages. The radiation protection supervisor confirmed that no staff had been subject to doses much higher than expected.
- The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For example, the treatment centre had a CQUIN target to implement a process to reduce the severity and increase the reporting of incidents at the treatment centre and to ensure lessons were learnt from every incident. The treatment centre had achieved all of its CQUINS during April to June 2016.

Competent staff

- The learning needs of staff were identified using annual appraisals. At the time of our inspection all staff had an up to date appraisal.
- There were arrangements in place for supporting and managing staff. There was a corporate Care UK supervision policy that stated staff should participate in supervision every three months. An audit in September 2016 had noted some shortfalls in compliance with this policy, such as the requirement for supervisees to complete necessary documentation prior to and after the supervision session plus the need for increased staff awareness of the purpose of supervision and the requirement to set targets. The team planned to introduce a log to ensure that the process of supervision could be audited more effectively. Another audit was planned for December 2016.
- All staff received appropriate training to meet their learning needs. Staff told us their managers supported them to attend external courses relevant to their role. New staff in the outpatient department received a comprehensive induction and participated in a six months' probation period. This included two to six weeks as supernumerary. Bank staff participated in the same induction and mandatory training as full time employed staff.
- We saw the competency assessments of all radiography staff which were comprehensive and up to date. There were no assistant practitioners working in radiology and all staff administering radiation were appropriately trained to do so.
- Staff were encouraged and given opportunities to develop. For example health care assistants were trained to complete biometry for ophthalmology patients. This training took six weeks to complete after which time staff were permitted to administer local anaesthesia eye drops and dilating eye drops.
- Pre-employment and pre-engagement accreditation of medical staff was in accordance with the NHS employment check standards. The medical staff induction process was managed by the onsite medical director and speciality leads. No appointment was confirmed as substantive until rigorous evidence based competency checks were successfully completed during the six month probationary period. On-going checks, such as GMC registration renewals, were managed centrally by the medical director, in accordance with their clinical staff registration policy. We were presented with evidence of medical staffing records and found the documentation complied with Care UK policy, as all documentation in respect of references, proof of professional registration, GMC registration, appraisal documentation and DBS checks were present and up to date.
- As part of the appraisal process the medical director discussed with each consultant their individual scorecards which contained detailed information about the volume of surgeries performed, outcomes of patients, readmissions, revisions, cancellations, rates of infection and venous thromboembolism. The medical director maintained relationships with the responsible officers for bank and self-employed consultant staff. This was to ensure oversight of appraisals being provided.
- All patients who received treatment at the treatment centre were funded by the NHS and so were covered by NHS indemnity, however the medical director encouraged consultants to take out personal medical indemnity insurance.
- Radiographers working as practitioners had a scope of practice under which they work and had associated training in order to carry out their responsibilities. We saw evidence that the centre had a policy governing this and radiographers were adhering to it.

Multidisciplinary working

- Staff had the skills knowledge and experience to deliver effective care and treatment. Staff in outpatients and diagnostics worked together to assess and plan ongoing care and treatment in a timely way.

Good

Outpatients and diagnostic imaging

- Staff in outpatients told us there were positive working relationships amongst the multidisciplinary team. All staff told us they were confident to communicate concerns to colleagues.
- As part of the justification process to carry out exposure to radiation, the imaging service always attempted to make use of previous images of the same persons requiring the test, even if these had been taken elsewhere. These images were stored on the electronic picture archiving and communication system and were accessible to all the diagnostics team.
- The diagnostics service ensured that images were reported on within 48 hours. In radiology, the sonographer and radiologist noted any scans which had seemed out of the ordinary, for example where differential diagnoses might be evident, and then followed up the results of that patient with the GP, for the purposes of sharing learning.
- In the ophthalmology clinic, the consultant ensured that patients received the best possible outcome by referring patients back to the local trust if more specialised equipment was needed for accurate diagnosis. For example during one outpatient consultation the consultant was unable to clearly see the back of the patient's eye using the equipment available at the treatment centre. He referred the patient for an examination using more specialised equipment at the local trust and this revealed an eye tumour.

Seven-day services

- The outpatients and diagnostics service was available Monday to Friday with occasional clinics held on Saturdays if demand arose. Some clinics opened until 7pm.
- Patients were given a telephone advice line number to contact the inpatient facility at Bristol, if they had any concerns outside of these working hours.

Access to information

- The information needed to deliver effective care and treatment was always available to staff in a timely and accessible way. Access to patients' full medical records was not available; however a referral letter was received from the patients GP that included a minimum data set for all patients. The information received from GP's and the health questionnaires completed by patients prior to their procedures were scanned into an electronic database and was available throughout the patient journey electronically and on paper format.
- Patient alerts were visible on the electronic record system. Staff added specific alerts in the free text box on the electronic record. For example drug allergies and learning disabilities.
- When patients telephoned the out of hours advice line, clinical information regarding patients' condition was instantly accessible on the electronic record system for the clinician taking the call to assess and advise accordingly.
- All outpatient registered nurses and a selection of healthcare assistants could access haematology and microbiology results via the electronic record system which connected with the local acute trust. If a patient's surgery was more than three months after the date of their original blood test, the patient experience nurse arranged for a repeat blood test to ensure that up to date haematology results were available to the surgery team.
- When patients left the outpatient department they were given a copy of the consent form they had signed. A letter was sent to their home address detailing confirmation of their surgery date and time and providing the telephone number of the patients experience nurse and their office hours.
- The electronic systems that managed information about patients supported staff to deliver effective care and treatment in the diagnostics service. Radiology images were stored on the electronic picture archiving and communication system and were accessible to all the diagnostics team.
- Referral information for radiology was received via the electronic administration system and also in paper format. Once imaging was completed, the radiographers marked the referrals as completed and scanned them onto the electronic record system, which was accessible to the multidisciplinary team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with demonstrated understanding of consent and decision making requirements which was in line with legislation and guidance, including the Mental Capacity Act 2005.

Good

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- Staff received mandatory training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS). Staff within the outpatient department had achieved 100% compliance. All policies in relation to MCA and DOLS were available in the clinical leads office and online and could be accessed at home.
- There were systems in place to support patients, living with dementia, to make decisions. For example in outpatients a separate consent form was used to obtain consent for patients living with dementia. The form included an assessment of the patient's capacity and requested confirmation of the following: whether the patient was unable to comprehend and retain information material to a decision on treatment, whether the patient was able to use or consider the information in the decision making process, whether the patient was unconscious, whether a mental capacity assessment and best interest check had been completed, whether the patient had refused a procedure in a valid advance directive/decision document and whether colleagues and those close to the patient had been consulted. The form also requested information on why the healthcare professional judged the procedure to be in the patient's best interests, why the treatment could not be delayed until the patient recovers capacity, what the intended benefits of the procedure were and any associated risks.
- However, patients living with dementia attended the outpatients and diagnostics departments very rarely. On one occasion when a patient with dementia attended the department, the wrong consent form was used. This was reported as an incident and learning was shared regarding the relevance of the dementia specific consent tool.
- The outpatient department team ensured that patients were fully informed during the consent process. For example, in the ophthalmology outpatient clinic, the team used a consent booklet printed in larger font that clearly outlined all aspects of what the patient was consenting to. This hard copy was in duplicate which allowed both the treatment centre and the patients to keep a copy of what had been agreed.
- The process for seeking consent was audited and overall compliance with obtaining consent in outpatients was 97%. Areas of non-compliance were due to staff not confirming consent information and patients declining information. Managers discussed this with staff to ensure the consent form was used appropriately and that staff understood how to check patients understanding.

Are outpatients and diagnostic imaging services caring?

Good

We rated outpatients and diagnostic screening as good for caring because:

- Patients gave positive feedback regarding their care in the outpatients and diagnostics service. The majority of patients were extremely likely or likely to recommend the service to others.
- Staff showed an encouraging, supportive and sensitive approach toward patients.
- All patients were chaperoned for all appointments.
- Staff used communication skills to provide reassurance to patients who needed emotional support.
- Most patients were given adequate information in response to their questions. However there were some exceptions.
- Staff took action to minimise risks to the privacy of patients.

However;

- Not all staff took action to minimise risks to the privacy of patients during outpatient consultations. We overheard conversations between a patient and consultant taking place in an adjoining consultation room.

Compassionate care

- People were treated with kindness, dignity and respect while receiving care and treatment. During September 2015 to end August 2016, 90% patients in the outpatient department said they were extremely likely and 9% said they were likely to recommend the service following their pre-operative appointment. Fifty seven percent of these patients went on to give more detailed answers about the service received, and these answers indicated that 100% of patients felt their wishes were respected definitely or to some extent and they were treated with respect and dignity during their appointment, 99% of

patients said there was always enough privacy when discussing treatment, 97% of patients always had trust in the person seeing them. All free text comments reviewed were positive about the friendliness, efficiency of staff and staff ability to put patients at ease. In diagnostics, 100% of patients indicated they would recommend the service to friends and family.

- During our inspection we received fourteen comments cards from patients. Twelve of these were very positive regarding the care received at the treatment centre.
- Staff took the time to interact with people who used the service and those close to them in a respectful and considerate manner. We saw that staff introduced themselves by name.
- Staff showed an encouraging, sensitive and supportive attitude to people who used services and those close to them. For example, we saw that when patients experienced anxiety, staff responded in a compassionate and appropriate way.
- The corporate chaperone policy stated that all intimate examinations were chaperoned unless explicitly refused by the patient. For less intimate examinations chaperoning was offered as a choice for individuals. Staff told us that all patients were chaperoned for outpatient consultations and during sonography appointments. This helped patients to feel at ease in situations when their privacy and dignity was at risk of feeling compromised.
- However, patients' privacy and dignity were, at times, compromised by the layout of the outpatients department. Staff did not take action to minimise this risk. For example, patients checked in at the main reception and patients were not always able to speak to the receptionist without being overheard. There were two adjacent consulting rooms joined by an internal wooden door. Both rooms were in use at the time of our observation. Although the door was closed between the rooms, we noticed that the consultant's conversation with the patient in the adjoining room was clearly audible to another patient attending for pre-operative assessment.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so that they understood their care, treatment and condition**.** Staff made sure that patients and those close to them were able to find further information and ask questions about their care and treatment.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment. We observed nursing staff explaining simple procedures in order to relieve anxiety for a patient. For example, the nurse explained what to expect during their surgery, the reason for wearing dark sunglasses in the theatre and the requirement to wear an oxygen saturation monitor on their fingertip. Five patients whom we interviewed and five comments cards received during our inspection gave very positive feedback regarding the reassuring and helpful manner of nursing and consultant staff.
- However, an outpatient nurse explained that 'there is always the pressure of time'. We saw that one patient asked for information regarding a sedative but this leaflet was not available because staff were awaiting a delivery. The patient was advised to 'google' the name of the medicine for more information. One patient said that the consultant did not help her to understand the reason for her operation or the pathology of her condition. One patient comment card said that staff were rude and did not explain things properly.
- Following their appointment, patients told us that they understood how and when they would receive test results. Nurses involved patients in making the decision regarding the date of their surgery and patients usually left the treatment centre with a date for their pending surgery jointly agreed.
- When patients were asked in the outpatient survey whether they knew what would happen to them at their appointment, 57% of patients said definitely and 35% to some extent, leaving 8% who did not feel prepared in this way. When asked if they felt involved in their treatment, 96% of patients said definitely and 4% said yes to some extent.

Emotional support

- Staff used their communication skills to provide reassurance to patients during their outpatient consultations. We observed a patient consultation in clinic and saw nursing staff using humour to reduce the anxiety levels of a patient. A health care assistant in

Good

Outpatients and diagnostic imaging

outpatient gave an example of a patient with Downs's syndrome who felt anxious during an eye examination. She held the patient's hand during the examination and allowed extra time for completion of the examination.

- The patient experience nurse took into account the patients levels of anxiety when allocating the patient a time for their surgery, for example some patients preferred to have their surgery at the beginning of the day to avoid an anxious wait.
- Patients told us they were given the contact details for the treatment centre and for the out of hour's helpline. This was confirmed in the results of the outpatient survey that indicated 92% of patients indicated they were definitely told who to contact if they had any worries or concerns after they left the treatment centre.

Are outpatients and diagnostic imaging services responsive?

Good

We rated outpatients and diagnostic imaging as good for responsive because:

- Patient safety acceptance criteria were used by triage nurses to ensure that only patients whose needs could be safely met were accepted at the treatment centre.
- Patients were given a choice of locations for their outpatient appointment.
- Theatre schedules were prepared three months in advance to allow time for outpatients to be given a date for their surgery at their initial appointment.
- Referral to treatment times were within 12 weeks. Since December 2015, patients had waited no more than six weeks for their diagnostic investigation
- Radiology images were reported on within 24 hours.
- Multidisciplinary meetings were held to discuss the requirements of patients with additional needs such as a learning disability. Reasonable adjustments were made such as encouraging carers to attend the outpatient appointment and booking double appointment slots.
- For all patients aged 16 to 18 years, the registered sick children's nurse was available to complete the pre-operative assessment or to telephone the patient to discuss their individual needs.
- Facilities were designed to effectively meet the needs of patients with mobility difficulties.
- Complaints were investigated thoroughly and learning was shared across teams.

However;

- The percentage of patients who did not attend for their appointment was high for initial and follow-up dental appointments. To address this, appointment letters had been amended to include the requirement for patients to confirm attendance prior to the appointment.
- Some aspects of the clinic environment were not well designed to meet the needs of patients with visual impairment.
- Some patients waited longer than one hour for their appointment.

Service planning and delivery to meet the needs of local people

- Services were planned to meet the needs of people.
- The treatment centre received business from several clinical commissioning groups as well as two acute trust hospitals. The treatment centre director frequently liaised with commissioners on an informal basis and met formally at regular intervals.
- The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. The treatment centre provided quality reports for each commissioning group and partnership, specific to the key performance indicators and CQUINs set by that commissioner. These CQUINs had all been met by the treatment centre during April to June 2016.
- The treatment centre used patient safety acceptance criteria to ensure that the treatment centre only treated patients whose needs could be safely met by the facilities offered on site or at their partner location**.** These criteria were reviewed annually in conjunction with GP leads and the treatment centre anaesthetist**.**
- Facilities in the clinic environment were well designed to meet the needs of patients with mobility difficulties. For example, there was adequate free car parking with marked disabled bays on one level immediately adjacent to the treatment centre entrance, armchairs were high backed with armrests, and a wheelchair was available in the reception for patient use.

Good

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- Theatre lists were prepared by the multidisciplinary scheduling group three months in advance to allow patients the option to arrange a mutually agreeable date for their surgery at the time of their outpatient appointment. We saw that staff listened to patients requests to avoid their planned holidays and staff arranged later appointments for patients who were required to travel further. During June and July 2016, 97.7% of patients left their outpatient appointment with an agreed date for their surgery.
- The working hours of staff in the outpatients department had recently changed to meet the preferences of patients' choice of appointment times.

Access and flow

- Patients were able to access care and treatment in a timely way.
- Patients received an appointment letter that explained their appointment at the clinic could take approximately two to three hours. This appointment time included necessary pre-assessment consultations.
- In August 2016, the referral to treatment times varied depending upon the specialty of surgery offered. The longest wait was 12 weeks for urology and ten to 12 weeks for dental surgery, the shortest wait being six to eight weeks for ophthalmology, general surgery and joint surgery.
- The percentage of patients that did not attend for their appointments varied according to the specialty of the clinic. In dental surgery, rates of non-attendance were high at 25.2% for first appointment and 20.9% for follow up appointment. The non-attendance rate for this specialty had increased following a move from a one-stop process i.e. pre-assessment and surgery on the same day, to a two stop process due to changes in guidance around the use of sedation. To address the high rates of non-attendance in the dental specialty the treatment centre had revised their appointment letter to include a requirement for the patient to confirm their attendance prior to the appointment.
- For ear, nose and throat surgery, rates of non-attendance were high for follow up appointments at 9.9% and 9.5% for orthopaedic surgery. Overall the rate of non-attendance for first appointments was 13.1%. However, in other specialties such as ophthalmology the rates of non-attendance were low at 2.4%, and in urology there were no patients who failed to attend for their appointments in outpatients. In all specialties other than dental, the rates of non-attendance were assessed on a case by case basis and the commissioners informed.
- At the time of our inspection, booking efficiency of outpatient clinics was below the predicted rate for some specialties such as gynaecology at 39%, ear nose and throat at 67%, dental surgery at 88%. Booking efficiency for orthopaedic surgery and for urology was meeting targets set by the treatment centre. The management team attributed this to generally declining activity levels and were addressing this through ongoing negotiation with commissioners and by focussing on public engagement at open days, and seeking joint advisory group accreditation of the endoscopy unit. When outpatient clinics were low in numbers, staff were deployed to other areas of the treatment centre or to the inpatient facility at Bristol.
- During March 2016 to end of August 2016 there were 19 outpatient clinics cancelled. The reasons for these cancellations included: capacity not required, consultants were unavailable due to sickness or annual leave, training, meetings or appraisals, and staff deployed to theatres where there was a greater demand.
- During January 2016 to March 2016 the outpatient department received 4,634 patients, 9% of these patients waited for longer than one hour. The average waiting time for appointments was 27 minutes. The reason for these long waits was not identified.
- When waiting time exceeded twenty minutes, the nurses informed the receptionist, who ensured all patients were informed of the reason for the delay. When patient appointments were delayed, staff informed them of the expected time of completion so that waiting relatives could leave and return.
- The service was flexible to meet patients' needs. Where possible, patients were given the choice to attend their outpatient appointment at either the Bristol or Devizes location, depending upon their convenience and irrespective of where the surgery would be completed.
- Since December 2015, patients had waited no more than six weeks for their diagnostic investigation
- Radiology images were reported on within one day by the radiologist based at the Care UK inpatient facility at Bristol. Sonography images were reported on within one day by the sonographer with support from the

radiologist. The exception to this response time were patients referred by a local trust for imaging only. These patients received their scan then waited for the local trust to report on the image.

- Radiology staff made exceptional effort to offer flexible response to patients' needs. For example, a certain patient needed their scan to be reported on prior to his outpatient appointment. The radiologist planned to come in to work during their annual leave in order to complete this task because they knew that the patient was anxious to return to work.

Meeting people's individual needs

- Staff in the outpatient service ensured that the care they delivered took account of the needs of different people. A health care assistant in outpatients gave an example of a patient with mobility difficulties. She informed the consultant and the patient was able to have their consultation directly after the biometry so that they were not required to walk the corridor twice. The patient experience nurse identified a patient with anxiety during a pre-operative telephone call. The nurse organised the theatre list so that this patient could go straight for surgery to avoid waiting.
- Services were consistently planned, delivered and coordinated to take account of people with complex needs. If a patient was identified at triage or pre-assessment as having complex or additional needs, the team held a multidisciplinary meeting to determine how best to meet the individuals needs and to ensure all staff were well informed regarding their particular requirements. For example a patient with a learning disability attended the preoperative clinic and the nurse identified that the patient was anxious regarding their surgery. The patient experience nurse convened a multidisciplinary meeting and arranged for the patient to visit the post anaesthetic care unit prior to the date of their surgery. These meetings were recorded in the electronic patient record.
- Support for people with a learning disability was available. When a referral was received for a patient with a learning disability it was usual practice to telephone the carer prior to the outpatient appointment and the patient was offered a double appointment slot in outpatients to ensure sufficient time for explanations.
- Outpatients and diagnostic staff took action to remove barriers when people found it hard to access or use services. For example staff could access a telephone language translation service. However, staff recognised that frequently patients with dual sensory loss could not hear the interpreter on the telephone and for this reason they tried where possible to arrange face-to-face interpreters. Sign language interpreters were also available. In the waiting area there were patient information leaflets available in braille, Bengali and Arabic.
- Support for young people aged 16 to 18 years was available. An individual young adult risk assessment was completed at the preoperative clinic for patients aged 16 to 18 years. The registered sick children's nurse (RSCN) carried out the pre-operative assessment for patients in this age group whenever possible. If this was not possible the RSCN telephoned the patient prior to the procedure to ensure that all their individual needs were anticipated.
- Where possible the patients aged 16-18 years were scheduled to be early on the morning list but were also given the opportunity to choose their appointment time to fit in with school or college commitments. Parents were encouraged to accompany their young dependant to their outpatient appointment if consent was given.
- However, some aspects of the environment of the clinic were not well designed to meet the needs of patients with visual impairment. This was because: floors were shiny, a similar colour was used for flooring, doors and door frames, labels identifying exit buttons were not well positioned and did not use easily distinguishable typeface.

Learning from complaints and concerns

- Complaints were addressed promptly and proactively and people received feedback. The head of nursing was responsible for ensuring that complaints were investigated and involved all relevant members of staff. All members of the senior management team reviewed letters of complaint. The head of nursing aimed to resolve patient concerns before they escalated to the formal complaints process. Staff felt able to interrupt the managers during any meeting if there had been an incident involving a patient or if a patient had a complaint. An example was given of a patient who did not understand the communication received from the consultant during an outpatient appointment. The head of nursing accompanied the patient to return to the consultant appointment and acted as their advocate during the consultation.

Good

Outpatients and diagnostic imaging

- There was a 'patient feedback zone' set up in the reception waiting area giving details of how to complain and feedback. The team displayed 'You said…we did' information for patients to see changes made in response to feedback, such as arranging for the hot drinks dispenser to be mended.
- The majority of patient complaints in outpatient concerned the time spent waiting in the department. Teams attempted to minimise the disruption for patients, for example by offering them the use of the phone to contact relatives at home and explain the delay
- If patients had made a complaint regarding their outpatient treatment, the head of nursing made sure that she was available to meet that patient during their return visit to the treatment centre. The head of nursing spoke to all staff regarding the handling of complaints during their induction period.

Are outpatients and diagnostic imaging services well-led?

Good

We rated outpatients and diagnostic imaging as good for well led because:

- There was a vision for the outpatient service to work closely with the primary care services. Future plans for the outpatient service included the introduction of a frailty screening system and a frailty lead nurse. Future plans for the diagnostics service included working towards accreditation with the Imaging Services Accreditation scheme.
- There were reliable systems for staff to identify and escalate risk. Risks were managed effectively and reviewed regularly.
- There was a monthly governance meeting attended by heads of department and senior management. Clinical activity during this meeting was suspended. This meeting was used to discuss and review key performance data and updates to clinical protocols and guidelines.
- There was a comprehensive programme of audit. Actions were taken to make improvements as a result of audits.
- The treatment centre was moving towards meeting the workforce race equality standards. An electronic database had been set up to record personal details volunteered by staff regarding ethnic background.
- Staff told us they felt supported by managers and their peers
- In the staff survey, 97% of staff felt proud of the work they did. The management team had made changes to improve integration of the Bristol and Devizes locations in response to the staff survey results in 2015.
- There was good engagement with patients. Patients participated in the friends and families test. The patient forum group had a positive impact on the patient journey.

However;

- There were mixed results regarding the staff survey, with staff feeling their managers did not effectively manage change affecting staff and staff satisfaction with immediate line management was lower than the average across Care UK locations. Some staff felt they were not treated fairly regardless of their race, ethnic origin, age, sex, sexual orientation or disability.
- On the risk register, details of the controls and gaps in controls were not consistently well defined. The risk register was not specific to core services and contained both open and closed risks. This meant that open risks specific to the outpatient department were less easily located on the risk register. However, senior management were aware of the risks and had implemented actions to address them.
- Team meetings in the outpatient service were infrequent and were not regularly attended by the manager for outpatients.

Vision and strategy for this core service

- There was a clear vision and strategy for the service aligned to the Care UK vision. The vision was to be the UK's leading independent provider for NHS elective care and to be the partner of choice for NHS commissioners, trusted to deliver the right care in the right place at the right time. Part of this vision was to differentiate themselves by the quality of services, ensuring innovative and customer focused care. Care UK described their values as: "our customers are at the heart of everything we do, every one of us makes a difference and together we make things better"

- At a local level, the treatment centre director identified that strategy was focussed on increasing the activity levels for treatment at the treatment centre. The team had organised a marketing campaign involving leaflet drops to the surrounding neighbourhood as well as an open day, where all staff were involved in demonstrations and tours of the treatment centre.
- Future plans for the outpatient service included the introduction of screening for frailty and the appointment of a frailty lead nurse. There was also a long term vision to work more closely with the primary care service, so that patients might come to the outpatient department for their primary care procedures. Frailty is a distinctive health state related to the ageing process. Older people living with frailty are at risk of changes in their physical and mental wellbeing after minor events which challenge their health, such as infection or new medication.
- There was a plan in place to meet the workforce race equality standards. This was overseen by the Care UK central committee attended by the medical director. At a local level, the operations manager was responsible for implementing the plan. The first stage of this plan had been completed, which was the setting up of an electronic database for staff to voluntarily submit details of their ethnicity. However, in the 2016 staff survey, only 66% of staff felt staff were treated fairly regardless of factors such as their race, ethnic origin, age, sex or sexual orientation or disability.

Governance, risk management and quality measurement

- There were reliable systems for risk and governance and for staff to identify and escalate risks. The treatment centre staff used an electronic governance dashboard that contained the incident reporting system, the electronic risk assessment process and the risk register. This system included an in-built notification system according to the severity score of the incident. All members of the governance and senior management team were notified of all incidents. The system created an auditable email trail that allowed the governance team to track progress in the investigation of incidents. The health and safety lead monitored trends evident in incidents reported and submitted a monthly report to the clinical governance team.
- The senior managers of the treatment centre were able to clearly articulate their key concerns. The treatment centre director identified two key risks for the treatment centre: the reduced activity levels and staff turnover rates. The senior management had identified these risks and implemented plans to address them.
- At the time of our inspection, the treatment centre used a combined risk register for both core services. The majority of the 35 risks on the risk register in March 2016 were specific to the surgery service. However eight risks were relevant to the outpatients and diagnostics service on the risk register, two of these were specific to outpatients and diagnostics and six of these were applicable to both the outpatients and diagnostics service and the surgery service
- The first risk specific to outpatients and diagnostics was the risk of potential harm to patients if their allergy status was not recorded. This was added to the risk register in February 2016 and was due for review in August 2016. The register identified the controls in place to mitigate this risk as well as the gaps in the controls and these were clearly auditable. We saw in minutes of meetings that this risk was frequently discussed and the governance report contained updates regarding the pharmacy interventions related to non-recording of allergies.
- The second risk specific to the outpatients and diagnostics service referred to the potential for clinical documentation to not be completed to a high standard if the clinic time was reduced by the efficiency maximisation programme. This was added to the risk register in March 2016 and was due for review the day after our inspection. However, in the minutes of governance meetings we reviewed, this risk was not discussed during the six months preceding our inspection
- Risks identified on the risk register were reviewed at monthly health safety and environment meetings attended by the senior management team plus clinical managers from each of the departments. We were told that all risks were discussed at the risk committee meetings held every three months and attended by the treatment centre director, the head of nursing, the medical director, the outpatient manager, the operations manager and the health and safety lead. Each risk had an identified handler and a review date. However minutes of these meetings were not sufficiently specific to identify progress against each risk.

Good

Outpatients and diagnostic imaging

- We saw that specialty governance meetings such as the thrombosis committee raised clinical risks such as a lack of training for venous thromboembolism prevention. These risks were then added to the risk register.
- There was also a treatment centre wide hazard register that identified generic risks such as lone working and power cuts. This register included risks that had been identified and assessed and those where no further action deemed necessary. For example, there had been one risk specific to outpatients regarding climate control in consulting rooms. This had been closed following provision of air conditioning. The treatment centre manager confirmed that the separate purposes of these two registers were not clear to all staff.
- There was a monthly governance meeting held at the inpatient facility at Bristol. All line managers including the outpatients' manager were required to attend these meetings four times per year. However, non-managerial staff in outpatients did not have a representative at these meetings. Although all outpatient staff were welcome to attend, they preferred to spend the half day per month catching up on their e-learning.
- The newly appointed clinical governance manager recognised that further work was needed to educate and engage staff in the governance process. Plans to achieve this included review of all systems of governance at the treatment centre including the format of the risk registers, the introduction of peer to peer audits, managerial spot checks to validate the data from audits, and the re-organisation of the monthly governance meeting to encourage more staff at Devizes to attend. However there was no time scale set for the introduction of these initiatives.
- Some action was taken to review governance systems. For example, the audit process was reviewed at the audit committee meeting in June 2016 and teams agreed to focus on streamlining the systems for reporting and presenting audit results.
- The staff attending monthly governance meeting discussed key performance reports. Performance against key performance indicators were reported by treatment centre site at the monthly governance meetings. Data for review included number of transfers out, number of conversions to overnight stays, number of readmissions and numbers of patients returned to theatre. For Devizes these were all achieved for May 2016. This meeting was also a forum for discussing the impact of updates to clinical guidelines. For example with regards to NICE guideline 'NG45 Pre-operative tests for routine elective surgery', the outpatient manager and lead anaesthetist discussed the requirement for urinalysis in asymptomatic patients
- When changes to clinical protocol was required or introduced, clinical staff discussed these at the clinical heads of department meetings. We looked at the minutes of these meetings and saw that teams discussed how the introduction of a revised policy for venous thromboembolism required consultants to categorise procedures as minor, intermediate or major. Revisions to the risk register were also discussed at this forum, including completion of the venous thromboembolism documentation.
- Governance reporting was complicated by the assurance requirements of several different commissioners. Members of the senior management team met with commissioners at contract review meetings to discuss clinical governance issues and contract concerns. These meetings occurred with varying regularity for each commissioner. The treatment centre director and head of nursing and clinical services met regularly with one of the local acute trusts for whom they were subcontracted to carry out surgery. At these meetings various aspects of governance were discussed including medication errors, referral rejections, results from friends and families tests.
- Performance against all service level agreements was reviewed at the senior management meeting held every three months. The contracts for service level agreements were reviewed at a corporate level.
- Staff were encouraged to attend corporate level governance groups relevant to their specialty. For example, the outpatient manager attended the Care UK documentation committee, the radiography manager attended the corporate governance meetings for radiology every three months and the sonographer attended the corporate sonography meetings every three months.
- The outpatients and diagnostic services participated in a corporate audit programme that included infection prevention and control plus areas such as: venous thromboembolism audit, medicines management, documentation, information governance and information security, emergency scenario. Action was taken to make improvements as a result of the outcomes of the audits etc. For example following the

health and safety audit of the outpatients department in April 2016, action had been taken to repair faulty doors and refrigerator plus health and safety was added to the agenda of all future meetings.

- Meetings were held for the outpatient's team at Devizes. Minutes were taken and these minutes were available for staff to review the information shared at the meetings. However we saw that there had been only three meetings in the six months preceding our inspection. Some staff, including the outpatients manager, had attended this meeting only once during this period. This meant that key staff were not regularly meeting face to face to discuss and record concerns.

Leadership / culture of service

- Local leaders reported they had autonomy to make positive changes to the patient's journey and were empowered by the senior management team.
- There were resources to help staff who needed support, for example there was a counselling service and a confidential human resources helpline for staff. A member of outpatient staff told us that the management team had been very supportive during a time of bereavement. In the 2016 staff survey, 100% of staff indicated that they knew what was expected of them at work, and were aware of assistance available to them in terms of occupational health.
- Managers showed appreciation for the effort and good work done by staff. There was a staff recognition scheme across Care UK, each month winning staff members received an award pin and all winners attended an annual award ceremony in London. Staff received a birthday card and present on their birthday. In the 2016 staff survey, 97% of staff felt proud of the work they did.
- Staff told us they felt supported by their managers and their peers. Occasionally outpatient clinics were held on a weekend. During these clinics we were told that there was always a manager on the premises. Staff at Devizes were able to access the managers at the Bristol inpatient facility on a twenty four hour seven days a week basis.
- However, in the 2016 staff survey, one of the lowest scoring questions indicated that only 40% of staff felt their manager effectively managed change affecting staff and ten percent of staff did not know who the senior managers were in their work area. Nine out of ten questions regarding staff member's satisfaction with their immediate line management scored lower than the average for the Care UK group.
- Staff morale was raised as a concern at the clinical heads of department meeting in June 2016. The treatment centre director acknowledged that the change in working hours for outpatient staff had had a negative impact on staff morale. To address this, the senior management team had explained the rationale to staff and managers told us they frequently reviewed activity levels and analysed patient choices on choose and book to ascertain whether staff requests for earlier start times could be re-introduced.
- Future plans for the diagnostics service was to work toward the Royal College of Radiologists Imaging Services Accreditation Scheme and to begin the process of sourcing new ultrasound equipment. The radiography manager had authorised the sonographer to take a lead on investigating new equipment suppliers.

Public and staff engagement

- There was a patient forum group that met every three to four months. This group was attended by patient representatives plus the head of nursing and clinical services, the treatment centre director, plus other staff members. This group had a positive impact on the patients' journey. For example, members of the patient forum were asked to evaluate the pain assessment tools and the patient information leaflets used at the treatment centre from a patient perspective. Minutes from the clinical heads of department meetings showed this feedback was discussed and action was taken, for example the pain tool was amended to be less complicated.
- Patients were encouraged to complete real time evaluations using hand held electronic devices made available to them in their outpatient appointment. There was a 59% response rate for the outpatient friends and family test in June 2016. This survey indicated that 100% of patients would recommend the service. During March 2016 to May 2016, the treatment centre achieved a 71.3% response rate for the friends and families test.
- The treatment centre held an open day last year and was planning another open day for October 2016. Local

residents received a flyer inviting them to attend. This included interactive teaching stands, with surgeons and nurses on hand to explain procedures to patients and members of the patient forum in attendance.

- The 2015 staff survey had highlighted a lack of integration with the inpatient facility at Bristol. Services on the two sites were line managed separately and followed different procedures, and this resulted in a lack of confidence in staff being asked to cover across both sites. In response the senior management team reviewed the management structure in early 2016 so that staff at Devizes and at the inpatient facility in Bristol were managed by one head of department covering both sites. Managers of the outpatients and diagnostics service both worked across the two locations and both agreed this had made a positive impact on integration.
- In 2016, the staff survey highlighted some concerns with staff engagement. At the time of our inspection the response rate for the outpatient staff survey was 67%. Some questions showed deterioration since 2015, such as 53% of staff felt they made a difference in the work they did compared to 65% the preceding year. Four of the five lowest scoring questions on the staff survey related to Care UK as a corporate employer, for example only 20% of staff said they would recommend Care UK as a place to work and only 34% said they would like to be working for Care UK in 12 months' time. Forty three percent of staff felt that action would be taken as a result of the survey and only 43% of staff felt action would be taken if concerns were raised at work. The action plan to address these concerns at a local level had not been finalised at the time of our inspection.
- There was a staff forum that met every three months. An actions arising from these forums included an issue of un-worked hours, which was addressed by the treatment centre director by creating a variable hours and overtime standard operating procedure. This formalised line managers' responsibilities in supporting staff to work their required hours by ensuring they are rostered appropriately.

Innovation, improvement and sustainability

- The ophthalmology clinic had recently introduced a new kind of eye drop that meant patients were not required to dilate their eyes at home prior to their appointment. This resulted in less inconvenience for patients, especially those with no carer available to assist them with this process.
- A new dental pathway had been trialled where fit and healthy patients were tested for blood pressure, height and weight during their outpatient appointment and completed their pre-operative assessment when they attended for theatre. This reduced the time that patients spent in the outpatient department on their initial appointment.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The treatment centre should ensure:

- Confidentiality is maintained when consulting rooms with adjoining doors are used simultaneously for different patients.
- The procedure for unloading trolleys of supplies is reviewed in relation to the requirement to maintain access to the fire exit at all times.
- Action is taken to reduce the percentage of patients who did not attend for their appointment in the dental surgery clinic.
- Consideration is given to make the environment of the outpatient clinic more accessible for patients with visual impairment.
- Regular team meetings occur at Devizes for the outpatient department and that these meetings are attended by the outpatient department manager.
- The functionality of the risk register is reviewed so that staff are able to clearly identify the measurable controls in place to mitigate risks as well as the gaps in controls. The risk register should clearly identify which core service(s) the risk applies to.