The Stratford Clinic

Quality Report

Alcester Road
Stratford-upon-Avon
CV37 6PP
Tel: 01789 412994
Website: www.thestratfordclinic.co.uk

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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Stratford Clinic is operated by SWFT Clinical Services Limited. Facilities include one operating theatre with a recovery facility and four consultation rooms.

The facility provides a range of surgical procedures and outpatient services. We inspected both the surgical and the outpatient services. Services include day-case surgical procedures and outpatient appointments for preoperative and postoperative review, as well as outpatient treatments such as joint injections, cryotherapy and mole mapping. In the reporting period of October 2016 to September 2017, there were 214 day-case episodes of care and 2396 outpatient attendances. The outpatient appointments were a mixture of patients accessing treatment and surgery outpatient consultations.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 21 December 2017, along with an unannounced visit to the clinic on 11 January 2018.

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

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

The main service provided by this hospital was surgery. Where our findings on surgery – for example, management arrangements – also apply to outpatients, we do not repeat the information but cross-refer to the surgery core service.

Services we rate

We rated this service as requires improvement overall because:

- Infection prevention and control processes were not adhered to at all times in relation to instrument decontamination. However, following our unannounced inspection we saw evidence that this process had improved.
- Swab, needle and instrument counts were not performed for cataract procedures.
- Policies were not reflective of the service.
- Patient outcomes were not monitored at the time of our inspection. The service did not participate in external audits and benchmarking.
- Controlled drugs were not stored appropriately or in line with the medicines management policy.
- There were no arrangements in place for patients living with dementia or a learning disability.
- There were no exclusion criteria to determine patients' eligibility for admission.
- The process of granting and reviewing practising privileges was not robust. The registered manager did not know what mandatory training, including safeguarding, consultants had undergone.
- Patient records and consent documentation was not always completed. Information required in consent forms such as dates, type of anaesthesia used and printed names were not always recorded.
- The clinic did not have a copy of all patient notes and there was no access to records policy in place.
- Not all staff had an up to date disclosure and barring service (DBS) certificate.

We found several areas of good practice:

- All areas of the clinic were visibly clean and tidy.
- Mandatory training had been completed by all staff.
- Records were stored securely.
- Patient feedback was very positive. Patients received compassionate care and their dignity was respected.
- There was an open and positive culture amongst staff. Staff of all levels worked well together.

Summary of findings

- The registered manager was very visible and approachable. The registered manager had implemented a number of new processes and standard operating procedures over the 15 months they had been in post.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected surgery and outpatients. Details are at the end of the report.

Heidi Smoult
Deputy Chief Inspector of Hospitals (Central)

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Location	Requires improvement 	
Surgery	Requires improvement 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as inadequate for effective, and requires improvement for safe, responsive and well-led. Surgery was rated good for caring. This was because: • Infection prevention and control processes were not adhered to at all times in relation to instrument decontamination. However, following our unannounced inspection we saw evidence that this process had improved. • Swab, needle and instrument counts were not performed for cataract procedures. • Policies were not reflective of the service. • Patient outcomes were not monitored at the time of our inspection. The service did not participate in external audits and benchmarking. • Controlled drugs were not stored appropriately, or in line with the medicines management policy. • There were no arrangements in place for patients living with dementia or a learning disability. • There was no exclusion criteria to determine patients' eligibility for admission. • There was no equality policy in place. • The process of granting and reviewing practising privileges was not robust. The registered manager did not know what mandatory training consultants had undergone, including safeguarding. • Patient records and consent documentation was not always completed.

Summary of findings

- The clinic did not have a copy of all patient notes and there was no access to records policy in place.
- Not all staff had an up to date disclosure and barring service (DBS) certificate.

However:

- All areas of the clinic were visibly clean and tidy.
- Mandatory training had been completed by all staff.
- Records were stored securely.
- Patient feedback was very positive. Patients received compassionate care and their dignity was respected.
- There was an open and positive culture amongst staff. Staff of all levels worked well together.
- The registered manager was very visible and approachable and had implemented a number of new processes and standard operating procedures over the 15 months they had been in post.

Outpatients and diagnostic imaging

Requires improvement

Surgery was the main activity of the clinic. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

Summary of findings

Contents

Requires improvement

The Stratford Clinic

Services we looked at
; Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to The Stratford Clinic

The Stratford Clinic is operated by SWFT Clinical Services Limited. SWFT Clinical Services Limited is registered under the Companies Act 2006 and is a wholly owned private subsidiary of a local NHS trust. The clinic opened in 2014. The Stratford Clinic is a private clinic in Stratford-upon-Avon, Warwickshire. The clinic primarily serves the communities of Stratford-upon-Avon. It also accepts patients from outside this area.

The registered manager had been in post and registered with the CQC since September 2016.

The most common procedures undertaken, were phacoemulsification of cataract with lens implant (cataract removal) followed by excision of skin lesions.

We carried out an announced inspection on 21 December 2017 and an unannounced inspection on 11 January 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors. The inspection team was overseen by an inspection manager and Bernadette Hanney, Head of Hospital Inspection.

Why we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 21 December 2017, along with an unannounced visit to the clinic on 11 January 2018.

How we carried out this inspection

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

During the inspection, we visited all of the consulting rooms, the recovery area and the operating room. We spoke with six staff including the registered manager, a consultant, registered nurses, a healthcare assistant and a receptionist. We also spoke with two patients.

We also received six 'tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed seven sets of patient records.

Information about The Stratford Clinic

The main service at the clinic was surgery. All surgery was performed under local anaesthetic or conscious sedation. Pre-operative and post-operative consultations were undertaken at the clinic, for surgery that was performed by the consultants at the clinic and at other local private hospitals. All patients were operated on and

Summary of this inspection

went home the same day, there were no overnight stays. The other service provided was outpatients. Outpatient treatments, for example; joint injections, cryotherapy, mole mapping and photodynamic therapy were also provided by consultants. Only patients aged over 18 were seen at the service.

The service has four consultation rooms, one operating theatre, and a recovery area and is registered to provide the following regulated activities:

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

During the inspection, we visited all of the consulting rooms, the recovery area and the operating room. We spoke with six staff including the registered manager, a consultant, registered nurses, a healthcare assistant and a receptionist. We also spoke with two patients.

We also received six 'tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed seven sets of patient records.

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

Activity (October 2016 to September 2017)

- In the reporting period of October 2016 to September 2017, there were 214 surgical procedures performed.
- In the reporting period of October 2016 to September 2017, there were 2396 outpatient appointments.
- In the reporting period of October 2016 to September 2017, 26% of patients were NHS funded. The clinic stopped treating NHS patients in August 2017.
- In the reporting period of October 2016 to September 2017, 35 patients under the age of 18 attended the clinic. The clinic stopped treating patients under the age of 18 in August 2017.
- The service had 11 consultants working under practising privileges. The service also employed four registered nurses, one healthcare assistant and a receptionist.

Track record on safety

- Zero never events
- Three clinical incidents which resulted in no harm
- Zero serious injuries.
- Zero incidences of healthcare associated MRSA.
- Zero incidences of healthcare associated Methicillin-sensitive staphylococcus aureus (MSSA).
- Zero incidences of healthcare associated Clostridium difficile (C.difficle).
- Zero incidences of healthcare associated Escherichia coli (E-Coli).
- One complaint

Services provided at the clinic under service level agreement:

- Clinical and non-clinical waste removal
- Maintenance of medical and specialist equipment
- Sterile services
- Domestic cleaning service
- Pharmacy services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Infection prevention and control processes were not adhered to at all times in relation to instrument decontamination. However, following our unannounced inspection we saw evidence that this process had improved.
- Arrangements for cleaning theatres were not robust. The theatre had not been deep cleaned for 12 months prior to the week of the inspection and floors in theatres were not routinely cleaned, if the theatre had been used on a Saturday, until the following Monday. However, we saw evidence that both issues had been addressed.
- Swab, needle and instrument counts were not performed for cataract procedures.
- Controlled drugs were not stored appropriately or in line with the medicines management policy. Documentation was not always completed appropriately when administering eye drops.
- Patient records were not always completed fully or accurately. The clinic did not have a copy of all patient notes and there was no 'access to records policy' in place.
- Full observations of vital signs were not always documented post-operatively.

However:

- Incidents were reported and lessons learned were shared amongst all staff.
- Processes for monitoring room and fridge temperatures ensured medicines were safe for use.
- Equipment was well maintained and resuscitation equipment was checked daily.
- There was always enough staff with the right qualifications to care for patients.
- Mandatory training compliance was 100% for nursing and administrative staff.

Are services effective?

Inadequate

We rated effective as requires improvement because:

- Policies were not reflective of the service. The service used an NHS trust's policies which could not always be followed or were inappropriate due to the difference in the way the clinic and the trust operated and the systems in place.

Summary of this inspection

- Patient outcomes were not monitored at the time of our inspection. The service did not participate in external audits and benchmarking.
- Not all staff had an up to date disclosure and barring service (DBS) certificate.
- The process of granting and reviewing practising privileges was not robust. There was no evidence of the consultant's scope of practice. There were no processes in place to review what mandatory training consultants had undergone, including safeguarding.
- Consent documentation was not always completed accurately.

However:

- Local audits had clear action plans attached to them and a clear criteria for repeating an audit when compliance did not meet the target.
- Most staff had received an appraisal with the exception of the registered manager.

Are services caring?

Good

We rated caring as good because:

- Patient feedback was extremely positive.
- Patients received compassionate care and their dignity was respected.
- Patients' confidentiality was maintained.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- There were no exclusion criteria to determine patients' eligibility for admission.
- Services were not always planned and delivered to take account of the needs of different people. For example, there were no arrangements in place for patients living with dementia or a learning disability.
- The clinic had not been adapted for patients with hearing loss.
- Waiting times for appointments were not formally monitored.

However:

- Patients had timely access from initial consultation to procedure, and postoperative follow up appointments.
- Reasonable adjustments had been made to ensure that disabled patients could access and use services on an equal basis to others.

Summary of this inspection

- There had been no complaints made to the service from October 2016 to September 2017. Information on how to make a complaint was available to patients.

Are services well-led?

Requires improvement

We rated well-led as (rating) because:

- There was no formal vision, strategy or a set of values in place at the time of our inspection.
- There was no formally documented governance framework.
- The senior team had not identified all risks to patients. Prior to our inspection, they were not aware of national standards that were not being met.

However:

- Staff feedback was gathered through staff meetings and annual staff satisfaction surveys. The 2017 staff survey was generally positive.
- The registered manager was very visible to all staff. Staff we spoke with said the registered manager was accessible, approachable and kind.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

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

Requires improvement

Surgery

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

Information about the service

The main service provided by this hospital was surgery. Where our findings on outpatients – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section.

For example, in this section we cover the hospital's arrangements for dealing with risks that might affect its ability to provide services (such as staffing problems, power cuts, fire and flood) in the overall safety section and the information applies to all services unless we mention an exception.

Are surgery services safe?

Requires improvement

Incidents

- Staff understood their responsibilities to raise concerns. Staff were able to provide examples of the types of incidents they would report, such as falls or needle stick injuries. During the reporting period of December 2016 to November 2017, there were 14 incidents. Of the 14 incidents reported, three were clinical incidents. All incidents had been classified as no harm or near misses.
- Staff used an electronic incident reporting tool to record incidents. Staff had received training on how to report incidents.
- There was an incident management policy dated December 2015. The policy was updated and managed by a local NHS trust. The policy did not reference The Stratford Clinic within the document.
- We reviewed all reported incidents and saw that actions had been taken to reduce the risk of reoccurrence. For example, there was an incident regarding an incorrect last name on a theatre list. Following the incident, the standard operating procedure (SOP) for finalising theatre lists was updated. This included a new requirement for staff to cross-reference patient's details on theatre lists with the details held on the administration system prior to the day of surgery.
- There had been no never events during the reporting period of October 2016 and September 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- People who used the services were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result. Staff were aware of the duty of candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations is the regulation that introduced the statutory duty of candour. For independent providers it came into effect in April 2015. Staff were able to explain the steps they would take in regards to apologising to the patient and being open and transparent about any failings in their care.
- We saw evidence that duty of candour had been applied following an unsuccessful lens implant during cataract

surgery on first attempt. The patient was kept informed throughout the procedure and an explanation was provided post-surgery. Actions taken were shared with the patient.

- Lessons were learned, both from incidents that had happened in the clinic, and those that happened in other NHS and independent hospitals. Action was taken as a result of investigations when things went wrong. Staff were able to provide an example of a patient safety alert issued by NHS Improvement around the risk of death and severe harm from ingestion of superabsorbent polymer gel granules. As a result of this alert, the registered manager had completed a risk assessment and moved the granules to a locked cupboard.
- Lessons were shared to make sure action was taken to improve safety. Senior team meetings, staff meetings and staff debrief meetings were held where any learning from incidents was shared. Staff also confirmed this despite there being no evidence of this in the staff meeting minutes.
- Daily informal conversations were held with staff regarding issues and incidents.

Clinical Quality Dashboard

- The service did not use a clinical quality dashboard. As all patients were undergoing brief outpatient or minor day-case procedures, and there were no inpatients, there was a very low risk of patients acquiring pressure ulcers whilst having treatment.
- Due to the nature of the surgery procedures performed, patients were assumed to have been assessed as not needing venous thromboembolism (VTE) prophylaxis but assessments were recorded in patients' notes. VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients.
- Surgical site infection (SSI) rates were monitored for all surgical procedures. This showed that no infections had occurred since the clinic opened in 2014.

Cleanliness, infection control and hygiene

- The operating theatre was compliant with Health Technical Memorandum (HTM) 03-01 Specialist ventilation for healthcare premises. This meant there were an adequate number of air changes per hour, which reduced the risk of infection. The annual compliance certificate was dated April 2017.
- All areas of the clinic were visibly clean and tidy on the days of inspection. The clinic had a contract with an external company, who cleaned the premises each evening Monday to Friday. However, on rare occasions when the theatre was used on a Saturday it was not thoroughly cleaned until Monday evening. The registered manager told us there were no theatre lists on a Monday and staff wiped surfaces after each theatre list. However, this meant the floor within the theatre was not cleaned from Saturday, if the theatre had been used, until Monday evening.
- The theatre had undergone a deep clean in December 2017, but had not been deep cleaned within the 12 months prior to this. However, this had been addressed; there were arrangements in place for the theatre to be deep cleaned on a six monthly basis.
- A local NHS trust was commissioned to provide an infection control service for SWFT Clinical Services. They audited environmental cleanliness and infection control practices annually. The audit was conducted using The Infection Control Nurses Association's Audit Tools for Theatres and Out-Patient Departments. The most recent audit was undertaken in September 2017 and the clinic achieved 100%. This was an improvement on the previous year, which showed a score of 96%. There was an action plan following each annual audit. All actions were completed.
- Hand sanitising gel dispensers were available throughout the clinic. We found the dispensers to be full and in working order. We observed staff washing their hands at appropriate times, for example, before and after patient contact.
- Staff adhered to being 'arms bare below the elbow' in line with NICE CG139. Monthly hand hygiene audits were completed by the registered manager. They were completed weekly if compliance fell below 95%. In July 2017, the hand hygiene audit result was 70%. The audit was completed weekly until it reached 100%. We reviewed the hand hygiene audits for August and September, which showed 95% and 100% respectively.

- An infection prevention and control policy was in place. This was in date and reflected best practice in regards to hand washing and use of personal protective equipment such as disposable gloves.
- The flooring in the consulting rooms were well maintained. They had a smooth coving between the wall and the floor. This was in line with Department of Health (DH) 2013 HBN0010 part A.
- Some hazardous cleaning chemicals were stored securely in a locked cleaning cupboard. Other cleaning chemicals were brought in by the contracted cleaners, who were only in the clinic after closing hours. There were weekly and daily checklists in place that had been completed to confirm the clinic was clean.
- Sterile services were supplied by a local NHS trust. Used surgical instruments were collected from the clinic on a Thursday evening and returned the following Monday once decontaminated, sterilised and ready for use. Used instruments were placed in a secure metal trolley specifically used for the transfer of dirty instruments. However, staff told us that when sterile instruments were used on a Friday and Saturday, the used phacoemulsification (for cataract extraction) hand pieces were rinsed in a sink within the dirty utility room and left next to the sink until the metal trolley was returned. This was not in line with HTM (01-01) 'Decontamination of surgical instruments'. The standard operating procedure (SOP) for the handling of instruments received from and returned to the hospital sterilisation and decontamination unit (HSDU) outlines that tray sets/instruments should be sprayed with an alkaline detergent should there be a delay in sending for decontamination. Not all staff were aware of this process. This was a breach of a regulation, which is outlined at the end of this report. We raised the rinsing of used instruments in the sink as a concern with the registered manager. During our subsequent unannounced inspection, we found there had been a temporary agreement put into place with the HSDU as surgical instruments were being collected for decontamination and sterilisation each day. However there were no permanent plans in place to address this issue at the time of our unannounced inspection. The registered manager told us there were no planned procedures taking place on a Friday or Saturday until the storage of dirty instruments had been resolved.
- Sterile instruments were stored in a closed cupboard. They were placed on top of each other with very limited ventilation. Temperature and humidity was not recorded. This was not in line with best practice guidance. We raised this as a concern and during our unannounced inspection, we found that the registered manager had a meeting arranged with the trust's HSDU manager to assess and review the storage space for sterile instruments. A thermometer had also been placed in the cupboard to monitor the room temperature.
- Waste management processes were in place but were not always followed. There were separate colour coded arrangements for general waste, clinical waste and sharps bins. Bins were not overfilled and sharps bins were closed, labelled and dated. However, we observed a member of staff using a plastic bag attached to the side of a clinical surface to dispose of empty plastic vials and tissues instead of the clinical waste bin provided.
- Scrubs (staff theatre attire) were single use and disposable. Staff told us disposable scrubs were not always available in their size. When disposable scrubs were not available in the correct size, there was an agreement in place with a local NHS trust whereby staff obtained clean scrubs from their linen room and returned them each day to be cleaned. Staff had designated shoes solely for use in theatre to prevent contamination of the theatre and reduce the risk of infection. This was in line with best practice guidance. Staff were responsible for ensuring they cleaned their own footwear.
- From October 2016 to September 2017, the clinic had no incidences of hospital acquired MRSA, Methicillin-sensitive staphylococcus aureus (MSSA), Escherichia coli (E Coli) or Clostridium difficile (C. difficile). Patients were not routinely screened for MRSA and C. difficile. These are infections that have the capability of causing harm to patients. Patients were not routinely asked at preoperative assessment if they had previously been infected.
- There had been no incidences of post-operative infections from November 2016 to September 2017.

Environment and equipment

- The clinic had an adult resuscitation trolley. This was stored between the theatre and the recovery room.

There was a checklist of contents and expiry dates. We reviewed the checking of resuscitation equipment and saw that they were completed daily in line with the clinic policy. All equipment was in date and was available in a variety of sizes to ensure all patients were catered for. During our announced inspection, there were no emergency medicines stored on the trolley. We raised this as a concern with the registered manager. During our unannounced inspection, we found emergency medicines such as adrenaline were stored securely in a tamper proof tagged bag on the trolley.

- There were processes in place for providing feedback on product failure to the Medicines and Healthcare Products Regulatory Agency (MHRA). The registered manager had informed the MHRA of an incident that happened during cataract surgery with a lens introducer. The manufacturer was also informed and the equipment was replaced.
- The facilities and premises were well maintained. The clinic was located on the ground floor and had adequate disabled access.
- The monitoring equipment in the theatre was checked prior to each surgical list by a nurse. The monitoring equipment had been appropriately serviced within the last 12 months.
- An audit of the environment was completed annually. The most recent audit was undertaken in September 2017 and the clinic achieved 100%. However, there were two concerns raised around equipment and the environment. For example, inappropriate items stored above lockers in the staff changing rooms. Items were removed on the day of the audit.
- Equipment was well maintained. There was an electronic database of all equipment, which showed all equipment had been serviced and electrically safety tested within recommended timeframes.

Medicines

- The service prescribed and administered medicines in line with current guidance. However, medicines were not always stored in line with the medicines management policy and documentation was not always completed appropriately when administering eye drops.
- There was an up to date medicines management handbook and policy. However, this was not always adhered to in relation to the storing of emergency medicines and controlled drugs (CDs).
- CDs were not routinely stored in the clinic however; processes for storing CDs when they were being used, was not followed. CDs were collected from the GP practice situated next door to the clinic and transported in a locked petty cash box. Staff confirmed CDs were stored in the petty cash box whilst they were in the clinic and not in the CD cabinet. This was not in line with the clinic's standard operating procedure. (SOP). The CD cabinet was within the medicines cupboard in theatre however, this was used for storing an intravenous lipid emulsion. Because CDs were not stored in line with legislation, Misuse of Drugs Regulations 2001, this was a breach of a regulation, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. which is outlined at the end of this report.
- There was a SOP that staff followed when collecting and returning CDs to the GP practice.
- Emergency medicines such as adrenaline, Atropine and Naloxone were stored in a locked medicines cupboard in theatre. This meant they were not easily accessible in an emergency. This was not in line with the clinic's medicines management handbook. However, the registered manager took action to address this. During our unannounced inspection, we found some emergency medicines had been placed in tamper tagged bags and placed on the resuscitation trolley.
- Medicines were stored securely in locked cupboards and the keys to medicines cupboards were only accessible to clinical staff. All medicines we looked at were in date.
- The keys for the medicines cupboard were stored in a keypad locked box in the kitchen. The secure code to the keypad had only been given to qualified nursing staff.
- An audit of medicines storage and handling was completed in October 2017. The clinic scored of 90%, which did not meet the target of 100%. This was due to intravenous fluids not being stored securely and the CD

register was not always counter-signed for supplied, administered and destroyed CDs. Action had been taken following the audit and issues had been addressed at the time of our inspection.

- Medicines requiring refrigeration were stored appropriately and temperatures were checked daily. We also saw records of the daily checks of ambient room temperatures and found they were completed.
- We reviewed seven medicine administration charts within patient records and saw that pre-operative eye drops were not individually signed for on two occasions. Allergies were recorded correctly.
- Pharmacy services were mainly provided by a local NHS trust. Eye drops for patients to take out (TTOs) following an ophthalmic procedure were prescribed by the consultant prior to surgery. TTOs were supplied by SWFT Clinical Services own pharmacy which was located off-site.
- Patients undergoing liposuction procedures were prescribed antibiotics following their surgery, to reduce the risk post-operative infections.

Records

- Patients' individual care records were not always complete. We reviewed seven records and saw that in two records there was not a full record of observations of vital signs post-operatively. Nausea scores were also not recorded following sedation. This was raised with the registered manager during our inspection who told us the clinic no longer offered sedation.
- Patient records were paper-based and stored securely. However, the clinic did not have a copy of all records for patients that had been seen at the clinic as some were taken away by the consultant. A copy of all surgical procedure notes were stored in locked cabinets. Records of patients who had received intravitreal injections or undergone pre-operative assessments or consultations at the clinic were kept by the consultants. There was no access to records policy in place should the clinic staff need to obtain the patients records. However, staff told us consultants and their secretaries were helpful if they required information about a patient's care.
- Consultants were responsible for bringing their own patient records to the clinic on the day of their clinic or theatre list. Each consultant was registered as a data controller with the Information Commissioners Office (ICO).
- The registered manager told us that all patients seen within surgery had all their relevant medical records available. The unavailability of records had been identified as a potential issue and a risk assessment had been completed.
- Patient's demographic details were held electronically and were accessed through individual log-ins and passwords. During our inspection, we saw computers were locked when staff were away from their desks. This reduced the risk of unauthorised people gaining access to confidential patient information.
- Patient documentation audits were completed twice yearly. The last two audits took place in January 2017 and May 2017. This was not in line with the clinic's audit schedule. The May 2017 audit showed 100% compliance with record keeping standards.

Safeguarding

- Staff understood how to protect patients from abuse and had access to a local NHS trusts safeguarding policies for children and adults.
- Staff we spoke with knew how to recognise safeguarding concerns and how to report them. Staff had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children. Staff were able to give examples of concerns they would raise.
- There was no designated lead for safeguarding at the clinic. However, staff had access to a local NHS trusts safeguarding lead for both adults and children for advice. Staff also had contact details for the safeguarding team at the local authority should they be required to make a safeguarding referral. Staff told us they would discuss any concerns with the registered manager and report them as an incident. This was in line with the responsibilities of all staff outlined in the safeguarding policy.
- Safeguarding training for consultants was not captured or monitored. This meant the registered manager and the provider could not be assured that consultants had

the appropriate safeguarding training. We raised this during our inspection and were told there were plans to capture this information as part of the practising privileges reviews. We spoke with a consultant who was unable to tell us what level of safeguarding training they had received.

- All staff employed by the clinic were trained in safeguarding adults level two. This was provided by the local NHS trust.
- Not all staff had valid disclosure and barring service (DBS) certificates. Two certificates had expired in 2017 and had not been renewed. We raised this with registered manager who told us this would be addressed immediately.
- The clinic stopped providing services to children and young adults under the age of 18 in August 2017. However, staff had received safeguarding children training level one, as to patients attending their appointments sometimes had children accompanying them. This did not meet the minimum training requirements set out by the Royal College of Paediatrics and Child Health (RCPCH) in 'Safeguarding children and young people: roles and competences for health care staff – intercollegiate document' (2014). The intercollegiate documents states that all non-clinical and clinical staff that have any contact with children, young people and/or parents/carers should be trained in level two safeguarding children. We raised this with the registered manager during our inspection and this was rectified. During our unannounced inspection, we found all nursing and administrative staff had completed safeguarding children training level two.

Mandatory training

- Consultants, who worked at the clinic under practising privileges, did not receive mandatory training from the service, but received this from their other places of employment. This was not monitored. The registered manager was working with the governance lead to explore ways in which compliance could be captured and monitored.
- All administrative and nursing staff had received mandatory training. Mandatory training included intermediate life support training, manual handling, health and safety, fire safety, infection prevention and control, information governance, anaphylaxis, medicines management, conflict resolution, dementia, equality and diversity, waste management, and safeguarding training. Compliance was 100% at the time of our inspection.
- There was a robust training record, which detailed the expiry date of each mandatory course for each staff member. The record was on the staff notice board. This was also monitored by the registered manager, who reminded staff to complete their training online or arranged face-to-face training with the relevant training lead at a local NHS trust.

Assessing and responding to patient risk

- There was a day surgery admission policy, which contained brief criteria. However, this did not clearly outline the eligibility or exclusion criteria for patients, to identify which patients were appropriate for admission. For example, the policy said fitness for a procedure should be determined at pre-operative assessment and not limited by ASA status. The American Society of Anaesthesiologists (ASA) score is an internationally recognised assessment criteria to ascertain whether a patient is fit for surgery. Those with an ASA1 score are fit, healthy patients. The lack of exclusion criteria was raised as a concern. The registered manager told us that an exclusion criteria was on the agenda to be discussed at the next clinical governance meeting in January 2018.
- The clinic offered day case surgery under local anaesthetic. However, patients are offered surgery under local anaesthetic with sedation for procedures such as liposuction with fat transfer. On these occasions, a consultant anaesthetist was available and remained in the clinic until the patient had been discharged. From January to December 2017, seven procedures had been performed using conscious sedation.
- Pre-operative risk assessments were completed for all patients. Patients were asked about their previous medical history. No blood tests were conducted due to the nature of the procedures the clinic offered.
- Staff told us there was a sepsis policy in place in line with NICE guidance NG51. This had been developed by a local NHS trust. We did not see a copy of the policy. Staff had a basic understanding of sepsis but had not completed sepsis training. Staff told us that in the event of a suspected case of sepsis they would dial 999.

Surgery

- The World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklists are surgical safety checklists that should be completed before and after surgery, to reduce the risk of errors. The clinic had incorporated a modified version of the safety checklist into their care pathway for cataract procedures. The checklist was fit for purpose providing all steps were completed.
- A copy of the checklist was in each patient's notes but they were not always fully completed and each checklist we reviewed varied. We reviewed six checklists and found some had signatures of staff members who were present in theatre and others had names printed. One checklist had a tick box for any concerns but this was left blank and the concerns were not noted in the patient's records. Staff told us there were no concerns with the procedure and the checklist had been filed without being completed.
- Needle, swab and instrument counts were not completed for cataract procedures despite the use, during the procedure of sharp instruments such as blades. This was a breach of a regulation and is outlined at the end of this report. WHO guidance states that low risk procedures can be exempt from the counting protocols, but they should be exceptions rather than a general rule. Association for Perioperative Practice (AfPP) guidelines state that a blade is a countable item. A blade was used during cataract procedures. Theatre staff completed a WHO surgical safety checklist when a cataract procedure was performed which confirmed all swabs, sharps and instruments had been counted and were correct. This was not an accurate record of the safety checks that had been completed as these checks had not been carried out but had been documented to show they had been. The lack of needle, swab and instrument counts was not in line with the clinic's own policy. 'Theatre checks for patients having a cataract procedure' policy, dated September 2017, stated that after surgery the WHO form (WHO surgical safety checklist) is completed and read out loud. This included the completion of instrument counts.
- Consultants gained information from patients GPs if they had a history of psychological or psychiatric problems.
- There was a process for identifying a deteriorating patient for patients under sedation. There were discharge checklists, which contained observation charts used in recovery. Observations such as blood pressure, pulse, activity level, nausea, surgical bleeding and pain scores were completed. We saw that observations were completed within patient records. There was a scoring system to identify if a patient had deteriorated or was fit for discharge. This complied with NICE guidance CG50.
- There was a modified discharge checklist in place for patients undergoing local anaesthetic for cataracts. Patients were required to be comfortable, eaten and drank, had their surgical site checked and had been reviewed by the surgeon prior to being discharged. Patients were also asked if they had someone take them home and stay overnight. Blood pressure and pulse was not monitored post-operatively for cataract procedures.
- The service ensured there was access to consultant medical input the whole time a patient was in the clinic. The surgeon remained in the clinic until the patient was discharged. As all patients were admitted and discharged on the same day and most had local anaesthetic, patients were discharged very soon after recovery once discharge checklists had been completed.
- On discharge, patients were given the clinic telephone number in case of any concerns following discharge. This number was used as a helpline during office hours. Out of office hours, patients were given the telephone number to a nearby independent hospital if they had any non-urgent queries. Patients also had access to their consultant's mobile telephone number. Patients were advised to dial 999 in the event of a medical emergency.
- Patients were discharged once they had recovered appropriately from their procedure and anaesthesia. Patients were encouraged to bring an escort with them and to collect them following their procedure.
- All patients received a welfare courtesy call the day after surgery from a nurse. If any concerns were raised during this call, they would be escalated to the surgeon. The nurse had a post-operative phone call checklist, which included discussions around the use of pain relief, eye drops, eye care, vision status, and whether the patient felt lightheaded or dizzy.
- An in date emergency transfer agreement was in place with a local NHS trust in the event of any serious

complications that required a patient to be transferred to hospital. A standard operating procedure relating to the emergency transfer was in place and staff were aware of the process. There was also an agreement with a local NHS trust whereby patients could access an inpatient bed if required. However, staff told us this had never happened.

Nursing and support staffing

- The service did not use any staffing tools to ensure that they had sufficient staffing levels to meet patient acuity and dependency. However, a minimum staffing level SOP was in place and adhered to.
- The clinic employed four registered nurses, one healthcare assistant (HCA) and a receptionist. The registered manager also carried out clinical duties as a nurse when required. There were two bank nurses employed.
- On inspection, we saw that staffing levels were sufficient, with each patient being attended to by a surgeon, a HCA and two registered nurses whilst in theatre. This met the Association for Perioperative Practice (AfPP) 2014 guidelines titled, Staffing for patients in the perioperative setting.
- There was one trained nurse allocated to admit, discharge, and care for patients whilst in recovery.
- The maximum number of patients a trained nurse would care for post-operatively was three at any one time. Nurses felt this was manageable. They told us that patients attended for their procedures at staggered times.
- Nursing handovers were not necessary as nurses and HCAs were required to work for the duration of a surgical list.
- There were no vacancies at the time of our inspection. There had been no turnover of staff or staff sickness during the reporting period of October 2016 to September 2017.

Medical staffing

- Medical staffing levels were appropriate for the procedures performed at the clinic.
- There were 11 consultants and one anaesthetist working at the clinic under practising privileges
- As all patients were either outpatients or had their procedure done as a day-case, there were no handovers or shift changes. The consultant surgeon remained with the patient until discharge.

Emergency awareness and training

- Major incident plans were in place. For example, an equipment power failure supply was available which would provide uninterrupted power for 20 minutes. An equipment or power failure SOP was in place. Staff we spoke with were aware of the SOP, what it entailed, and were able to locate the associated risk assessment.
- Fire evacuation tests and evacuation plans were also in place. The fire alarms were tested weekly by the adjacent medical centre. The most senior person on duty took the role of fire safety officer. All staff knew where the assembly area was and what to do in the event of a fire.

Are surgery services effective?

Inadequate

We rated effective as **inadequate**

Evidence-based care and treatment

- Patients had their care planned in line with evidence-based guidance or standards. Examples of this included having an agreement in place for patient transfers with a local NHS hospital and conducting venous thromboembolism (VTE) assessments.
- Audits to check compliance with national standards were completed. For example, the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklists are surgical safety checklist was audited monthly.
- Local audits were completed and actions taken were detailed for each audit where necessary. However, not all audit criteria was in line with national guidance or local policies. For example, the audit criteria for the storage of emergency medicines asked if emergency medicines were locked away securely. Although any

medicines do need to be stored securely, national guidance states that emergency medicines need to be easily available. Completed audits showed medicines were securely stored.

- As there were no clear clinical criteria for admission or exclusions, it was possible that the decision making process on whether to admit a patient could have been discriminatory. This was because it was based on the clinician's personal view of the patient, as opposed to clinical criteria.
- The registered manager and consultants we spoke with had some understanding of specific National Institute for Health and Care Excellence (NICE) guidance that was relevant to the services provided.
- Consultants and nursing staff attended training conferences to ensure their practice was up to date. Nursing staff fed back to the team on any courses they had attended.
- The clinic received notifications from NICE and the National Patient Safety Agency detailing updated guidance and quality standards. Notifications were reviewed by the registered manager and if they are relevant to services provided at the clinic, policies and standard operating procedures were updated. This was communicated to staff at staff meetings.
- Most of the clinic's policies had been developed for use in an NHS trust and therefore the content was not always relevant. Staff told us they were expected to be aware of and comply with policy content where possible. For example, governance and reporting processes were different in the policies to the processes staff followed. In addition, this issue was highlighted in the staff handbook. Most standard operating procedures (SOP) we reviewed that had been developed by the clinic, were clear, up to date and based on best practice guidance.
- Not all policies and SOPs were adhered to at all times. For example, controlled drugs (CDs) were not stored in the CD cabinet when they were present in theatre in line with the CD management SOP. Not all staff adhered to infection prevention and control policies, for example by using plastic bags to dispose of clinical waste instead of using the clinical waste bins provided.
- Patients were supported to be as fit as possible for surgery. For example, patients were advised to limit alcohol intake.
- Due to the relative infancy of the service, they had not submitted to the NICE shared learning database at the time of our inspection. There were no formalised plans in place to start this.
- The clinic did not benchmark their services against other providers, locally or nationally.
- The registered manager had key contacts at other independent hospitals and clinics, which offered similar services. They told us that they used their key contacts to share best practice, however; we did not see evidence of this.

Pain relief

- Patients had surgery under local anaesthetic or conscious sedation and any pain they had after their procedure was managed well.
- Patients who experienced pain in recovery could be offered Ibuprofen or Paracetamol. Staff told us this rarely happened and they were rarely required to provide pain relief.
- Medicines to take out (TTOs) included pain relief when necessary.
- The clinic did not conduct pain relief audits. We were told that patients did not complain about pain due to the type of procedures being performed.
- Patients were asked about pain prior to discharge and again over the telephone the following day.
- We were told that no patients had complained about their pain management as of October 2016.
- The service did not participate in the Anaesthesia Clinical Services Accreditation scheme. Anaesthesia Clinical Services Accreditation is a voluntary scheme for NHS and independent sector organisations that offers quality improvement through peer review.

Nutrition and hydration

- Patients' nutrition and hydration needs were met. Patients were offered snacks and hot and cold beverages following their procedure.

- Prior to surgery patients were asked when they had last consumed food and drinks. They were advised to withhold food for six hours before surgery and clear fluids two hours before surgery. This was in line with Royal College of Anaesthetists guidance.
- There was no prevention of nausea and vomiting protocol in place. There were no medicines available if patients felt nauseous after surgery. The registered manager told us this had never happened.

Patient outcomes

- Information about the outcomes of people's care and treatment were not audited and acted upon. Patient reported outcome measures (PROMs) were collected for cataract and carpel tunnel procedures and sent to an external company for analysis. However, at the time of our inspection the information had not been analysed. The service began collecting PROMS in August 2017 therefore, we saw no evidence that outcomes were audited and acted upon. Completion of PROMs, pre- and post-operatively, allows for a patient's own measurement of their health and health-related quality of life, and how this had been changed by the surgical intervention. PROMs are distinct from more general measures of satisfaction and experience, being procedure-specific, validated, and constructed to reduce bias effects.
- A consultant ophthalmologist had developed a form, which was sent to patient's optometrists following surgery. The form asked the optometrist to detail the patient's refraction and visual acuity achieved since surgery in an effort to understand patient outcomes. However, this data was not available to us. It was unclear if this information was being analysed and if it was used to improve the service.
- The service did not benchmark their outcomes to other services. Therefore, we were unable to see how they compared to similar services. However, the clinic had engaged with the Private Healthcare Information Network (PHIN) so that data could be submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA). Data was not accessible to members of the public via PHIN as data, at the time of our inspection, had only recently been collected and submitted.
- There was a clear local audit schedule in place. Hand hygiene, theatre debrief, and fire safety audits were completed monthly. NICE and MHRA alert audits were completed quarterly. Patient documentation and infection prevention and control audits were completed twice-yearly. Some audits were done more regularly depending on compliance. For example, where compliance was below 95%, audits were repeated weekly until compliance reached the clinic target. We saw evidence that this happened for hand hygiene audits.
- The clinic did not participate in any national audits. We were told work had commenced to identify which national ophthalmic audits the clinic could participate in with the view of participating from January 2018, but we did not see evidence of this.
- There were no unplanned readmissions within the reporting period of October 2016 to September 2017.

Competent staff

- Nursing staff directly employed by the clinic, had the right qualifications, skills, knowledge and experience to do their job. Evidence of their qualifications and skills was clear from their employment files, which we looked at during our inspection. All staff members had two references on file.
- There were processes in place for regularly checking the Nursing and Midwifery website to ensure that the nurses employed were not subject to any interim conditions or suspensions.
- All consultants had up to date Medical Defence Union (MDU) certificates in the doctors' electronic files, held by the clinic. MDU certificates provide evidence doctors have professional medical indemnity insurance.
- Staff employed by the clinic had evidence of mandatory training and their clinical qualifications necessary for their role. Equipment competencies were also stored electronically in staff files.
- All staff had completed basic life support (BLS) training. All clinical staff had completed intermediate life support (ILS) training.
- Most staff had received an appraisal within the last 12 months, including bank staff. However, the registered manager had never received an appraisal.

- External first assistants or advanced scrub practitioners are registered practitioners who provide assistance under the supervision of the surgeon, but were not used within the service.
- All consultants worked under practising privilege arrangements. The registered manager completed yearly checks of indemnity insurance, appraisals and GMC registration checks. However, there was no evidence of their scope of practice, mandatory and safeguarding training. This process was reviewed in 2017 and a new practising privileges policy was in place dated November 2017. The medical director had taken joint responsibility for reviewing all previous documentation and annual renewals. We were told a full detailed review of all practising privileges would take place every two years commencing in January 2018. It was planned that this would include obtaining information about scope of practice and information about training undertaken at the consultants' other places of employment.

Multidisciplinary working

- All relevant staff were involved in assessing, planning and delivering people's care and treatment. Treatment was consultant-led and involved discussions with the nursing staff and administrative staff where required.
- The team worked well together, providing care to patients. There were positive working relationships between the administrative team and the clinical team.
- Discharges were facilitated by nursing and medical staff who worked together to ensure the patient was fit for discharge
- Relevant information was shared between the service and the patients' GPs. Details of the surgery that had been undertaken, were sent to the patient's GP, in order to maintain a full chain of records.
- Patients who had undergone cataract surgery had the details of their surgery sent to their optometrist.
- There were service level agreements (SLAs) in place with a number of organisations including a local NHS trust. There were positive working relationships between staff and the local NHS provider who regularly provided advice to staff when required. Staff from the local trust carried out audits in the clinic, provided sterile services and pharmacy support to the clinic.

Access to information

- Staff told us information needed to deliver effective care and treatment was available to relevant staff in a timely manner. This was reliant on the consultants bringing their own patients records on the day of a clinic or a theatre list. A copy of all surgical procedure notes were stored in locked cabinets in alphabetical order and could be easily located. Records of patients who had received intravitreal injections, pre-operative assessments or consultations at the clinic were kept by the consultants.
- There was no access to records policy in place should the clinic staff need to obtain the patients records. Staff told us consultants and their secretaries were helpful if they required information about a patient's care.
- The registered manager told us that all patients seen within surgery had all their relevant medical records available. The unavailability of records had been identified as a potential issue and a risk assessment had been completed.
- Patients were asked for their consent to share information with their GP regarding and procedures and treatment. Patients, who did not consent for the service to contact their GP, were provided with a copy of their discharge summary and advised to show it to their GP.
- All staff were familiar with the electronic system and were able to navigate it well. We observed the receptionist, nurses and the registered manager using the administration system.
- All staff had access to a local NHS trusts intranet. They could access the trusts policies, pathways and best practice guidance via the intranet. Staff told us they used this regularly.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The clinic used a local NHS trusts consent to examination or treatment policy dated January 2017. The policy referenced the Mental Capacity Act 2005 and incorporated all aspects of the test for mental capacity. However, not all aspects of the policy were relevant to the clinic. For example, patients were not provided with written information about their procedure in braille or different languages as the policy stated.

- Staff understood the need for consent. A consent process was in place and written information including the risks and benefits of the proposed treatment or procedure was given to the patients. The information was discussed with patients during their consultation.
- We reviewed six consent forms. Three of six consent forms were incomplete. Three records did not have the name of the consultant printed as required on the form. In addition, one of the records also did not have a recorded date of consent and the check box of which type of anaesthesia would be involved was empty and left blank.
- Consent forms were audited twice yearly as part of the documentation audit. Audits showed that all patients received the relevant information prior to their procedure but forms were not always fully completed and signed appropriately by consultants. There was no action plans in place to address poor compliance with consent documentation.
- There were three different types of consent forms for different procedures. Not all fields on the consent forms were relevant for the services provided at the clinic. For example, the person giving consent was required to circle if they were the patient or the patient's parent however, the clinic no longer treated children. Consent forms also had the option of general anaesthesia however, the clinic did not provide any procedures under a general anaesthetic. At the time of our inspection, this particular version of consent form was also out of date and had been due to be reviewed in June 2016. We raised our observations around consent forms with the registered manager who took action to address all issues raised. During our unannounced inspection, we saw a new consent form had been drafted and was awaiting sign-off. The new consent form was clearer and more relevant to the patients seen in the clinic.
- Patients were supported to make decisions by being given realistic expectations about the outcome of their surgery. The information leaflets, given to patients during their consultation, which discussed the risks and benefits were very thorough, to ensure that patients gave fully informed consent.
- A two-week cooling off period was usually maintained between a patient consenting to a procedure and undergoing surgery. The two-week cooling off period was not in place for patients undergoing mole removals. We were told mole removals could be done on the same day as a consultation. Patients were encouraged to go away and think about the procedure and information given before coming back for their appointment.
- The rights of people subject to the Mental Health Act were protected. Staff were aware of what to do, in the event that a patient had mental health concerns. Nurses and consultants had an awareness of how to undertake mental capacity assessments, in accordance with the Mental Capacity Act 2005. Mental capacity assessment forms were readily available. However, staff told us they had never been required to formally assess a patient's capacity.

Are surgery services caring?

Good

We rated caring as **good.**

Compassionate care

- Patients' privacy and dignity was respected. Patients were cared for postoperatively behind curtains. Chaperones were available. Preoperative consultations and health questionnaires were always carried out in consultation rooms to maintain privacy. Patient satisfaction survey results from November 2016 to October 2017 showed that all patients felt they were given sufficient privacy during the entirety of their care.
- Staff understood and respected people's personal, cultural, social and religious needs, and took these into account. Staff took the time to interact with patients and always gave them the opportunity to ask questions. We observed patients being spoken to in a respectful and considerate manner at all times.
- Confidentiality was maintained in the service. Patients who called the service were not given any information until they had confirmed their name, date of birth and email address. They would then call the patient back on the telephone number they kept on file.

Requires improvement

Surgery

- We reviewed the patient satisfaction survey results from November 2016 to October 2017. These were very positive and showed that all patients were likely to recommend the service to their family and friends.
- We received 21 comment cards. These were also extremely positive with comments such as 'nothing to say but BRILLIANT' and staff were described as 'very friendly' and 'excellent'.

Understanding and involvement of patients and those close to them

- Staff communicated with patients in a way that they could understand their care and treatment. Information provided verbally was also given in writing in an easy to understand format.
- Patients were given time at the end of each visit to allow for questions they may have.
- Relatives of patients who required additional support were encouraged to stay with the patient if the patient wished for them to stay. For example, staff told us if patients were anxious about their procedure, they would ask if they wanted a friend or relative to stay with them throughout their time at the clinic.
- Patients were advised at the booking stage of all possible costs that would be incurred. This was also available on the website, so that patients were fully aware of the cost implications.
- Patients were told of all possible risks and benefits of the procedure they were proposing to undertake. Realistic expectations were set, so that they understood what the outcome would be. This was in line with NICE guidance QS15 Statement 5.

Emotional support

- Staff understood the impact that a person's care and treatment could have on their wellbeing. Staff were empathetic to patients who were anxious about their surgery and reassured them. For example, patients who were nervous about their procedure were invited to see the operating theatre and recovery room. Staff talked them through the process whilst walking the patient pathway.
- Due to the types of anaesthesia and short recovery times, patients were empowered to be independent and manage their own health very quickly after the operation.

Are surgery services responsive?

Requires improvement

We rated responsive as **requires improvement.**

Service planning and delivery to meet the needs of local people

- The service had been designed to meet the needs of patients who required a cataract procedure. However, the service did not consider all of the needs of different patients for example, those living with dementia.
- Information about the needs of the local population was used to inform which services were delivered. The type of services provided reflected the needs of the local population. The most common procedure performed was cataract removal. In 2017, the clinic provided cataract procedures for NHS patients who were on an NHS waiting list in order to decrease waiting times.
- Patients had provided feedback that they would like clearer directions to the clinic, and as a result, this was provided for all patients.
- Evening and weekend consultation appointments were offered to patients to provide flexibility and choice. Procedures were also performed on Saturdays. Postoperative checks were completed by the operating surgeon. Anaesthetists stayed in the clinic following any procedures under sedation. This provided continuity of care.
- The facilities and premises were appropriate for the services that were planned and delivered. There was a waiting area, four consultation rooms for consultation appointments, one theatre and one recovery room. This was sufficient for the number of patients seen.

Access and flow

- Patients had timely access from initial consultation to procedure, and postoperative follow up appointments. From records we reviewed, we saw that most patients had their procedure within five weeks of their

preoperative consultation. All patients were given a minimum of two weeks from consultation and procedure, to reflect on the information provided with the exception of patients who were undergoing a mole removal procedure. This particular procedure could be done on the same day.

- An appointments system was in use. Nurses, healthcare assistants and receptionists used the system and found it easy to navigate. Patients did not wait long for initial consultations, due to the flexibility of consultants and clinic opening hours.
- There were up to four theatre lists per week dependent upon activity lists. Each list contained no more than four patients.
- Waiting times were not formally monitored. At the time of inspection, patients could expect to wait up to one week for an initial consultation and four weeks for a procedure dependent upon the availability of the consultant they wished to see. Post-operative consultations occurred within a week of surgery.
- There were two cancelled procedures for non-clinical reasons from October 2016 to September 2017. Both procedures were performed within 28 days of the cancelled appointment.

Meeting people's individual needs

- Services were not always planned and delivered to take account of the needs of different people. The registered manager told us staff could access translators but would use relatives if they were in attendance. This is not in line with best practice as staff cannot be sure that, the translation is accurate or that the patient understands and agrees with the information.
- Patients who were hard of hearing were asked to inform the clinic prior to their appointment to allow for staff to make arrangements. Patients who required a sign language translator usually attended with an interpreter they had arranged themselves. We asked the registered manager how staff could be sure that the translation was accurate and were told that sign language interpreters who attended the clinic were trained and employed by recognised companies. Staff told us they wore their company ID badges and were asked to present their ID on arrival.
- There were no arrangements in place to help communicate with people living with dementia or those with a learning disability. We were told the clinic had never seen any private patients with a learning disability.
- Reasonable adjustments had been made to ensure that disabled patients could access and use services on an equal basis to others. All areas of the service were wheelchair accessible. The clinic was situated on the ground floor and doors were the appropriate size to allow wheelchair access.
- Staff told us they would not perform any procedures on pregnant women or those under the age of 18 and therefore provisions were not made for these patients. However, there was no exclusion policy that stated this.
- We were told that discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation was avoided when making care and treatment decisions. However, there was no equality policy in place at the time of our inspection.
- The service was able to refer patients for psychiatric support if required. Staff told us they would contact the patients GP or a local NHS trust if they felt they required psychiatric support. However, there was no service level agreement in place.
- There was no hearing loop available in the clinic for patients who were hard of hearing.

Learning from complaints and concerns

- Patients we spoke with knew how to make a complaint and were confident to do so. Information on how to make a complaint was detailed in customer complaints procedure document, which was displayed in the reception waiting area. This explained the process for making a complaint, including contact details and timescales.
- There had been no complaints from October 2016 to September 2017. Therefore, there had been no complaints referred to onto the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) in this period.

Requires improvement

Surgery

- The registered manager was responsible for managing complaints. Unresolved verbal complaints and written complaints were acknowledged by the registered manager within 48 hours. All complaints were investigated and responded to within 20 days.
- Staff were knowledgeable about the complaints process and were able to explain what they would do if a patient complained.
- There was a customer complaints standard operating procedure in place dated October 2017. This stated that staff must attempt to resolve all issues informally on initial receipt of a complaint.
- As there had been no formal complaints at the time of our inspection, we saw no evidence of complaints being discussed. However, we saw evidence that complaints were a standing agenda item at staff meetings and governance meetings. We also saw evidence of patient feedback and comments being discussed and acted upon at governance meetings and staff meetings.

Are surgery services well-led?

Requires improvement

We rated well-led as **requires improvement.**

Leadership / culture of service

- The registered manager was also the general manager of the clinic. They led the service and managed the healthcare division for the company. The registered manager was very visible to all staff. Staff we spoke with said the registered manager was accessible, approachable and kind.
- The Stratford Clinic formed the healthcare division of SWFT Clinical Services LTD. Other divisions included pharmacy and property. The senior corporate management team for the wider company was based off-site. The team consisted of the company chair, a managing director, a medical director, a quality governance manager, and the registered manager. Not all members of the corporate management team were visible to staff working at the clinic. During both our announced and unannounced inspections, not all members of the senior management team were present in the clinic.
- The registered manager did not always have enough support to allow them to be fully effective as they had a large number of responsibilities.
- We could not be assured the senior management team had taken appropriate action to ensure care and treatment was delivered in line with national standards. For example, appropriate access to emergency medicines and processes to decontaminate sterile equipment.
- All staff we spoke with enjoyed their roles and was proud to work at the clinic. There was an open culture within the service and staff felt valued and respected by their manager and each other.
- Staff worked well together and shared the responsibility of delivering care. Each member of staff were aware of their role and were committed to ensuring patients had a positive experience.
- We observed staff of all levels helping other members of staff complete tasks. For example, we observed the registered manager and a nurse helping the receptionist complete administrative tasks. We also observed nurses making drinks for patients who were waiting when the receptionist was occupied.
- The service ensured that all marketing was honest and responsible and complied with guidance from the Committee on Advertising Practice. For example, they did not offer any two-for-one deals to entice patients, or offer any seasonal discounts.
- A system was in place to ensure people using the service were provided with a statement that included the terms and conditions. This was done when patients registered with the service. Staff discussed these with patients and patients signed to show they had read and understood them.
- Staff rarely worked on their own. However, a lone working policy was in place dated September 2016, this ensured the safety of a lone member of staff opening the clinic prior to another member of staff arriving.

Vision and strategy for this core service

- There was no formal vision, strategy or a set of values in place at the time of our inspection. We were told this

was yet to be confirmed by the managing director. It was unclear if the service had made progress against what it wanted to achieve, as this was not formally documented anywhere.

- The registered manager was keen to expand on the range of services offered and increase theatre utilisation. However, their main focus was to implement and improve governance processes and maintain good quality care prior to any service expansion. This was not formally documented but we were told the managing director was supportive of this.
- All procedures were coded in accordance with the Clinical Coding and Schedule Development Group (CCSD). CCSD coding aims to standardise coding across the independent healthcare sector and is used for insurance purposes.
- A brief business plan was in place. This showed the clinics strengths and weaknesses and outlined how they were going to maximise opportunities to grow the business. The plan was dated 2016 to 2018 however it did not include any information for 2017/18.

Governance, risk management and quality measurement

- There was a governance structure in place however, this had not been formally documented. Clinical governance meetings were held quarterly, we saw minutes of these. They were attended by the registered manager and chaired by the medical director.
- Quality, performance, incidents and complaints were discussed at clinical governance meetings. The registered manager had developed a managers report which was included an update of all of these elements. This was tabled at each meeting to ensure clinical governance meeting members were aware of what was happening in the clinic.
- The registered manager told us they verbally kept clinic staff up to date of discussions held at the clinical governance meetings.
- Staff meetings were held quarterly. We reviewed meeting minutes from July 2017 and October 2017 but saw no evidence of incidents, incident reporting and performance data being discussed at these meetings. Meeting minutes were circulated to all staff.
- There was an up to date risk register and a newly developed risk management process in place. The risks related directly to the service and risks were discussed and updated at the risk, health and safety meetings. The highest rated risks were then reviewed at the clinical governance meetings. Staff were aware of the risks on the risk register despite there being no evidence that risks were reviewed at staff meetings.
- Each risk had an assigned risk owner, mitigating actions and dates for when the risk should be mitigated and reviewed. There were documented risk assessments behind each risk on the register. Each risk register entry had a source type recorded which explained how the risk had been identified. For example, some risks had been identified from incidents and others were identified hazards.
- There was some alignment between the recorded risks on the risk register and what the registered manager told us was on their 'worry list'. However, the registered manager told us they were concerned that governance processes were not yet robust, however, this was not identified as a risk to the service on the risk register. There was also a risk around policies not directly relating to the service as they had been developed for an NHS provider but this had also not been formally recorded on the risk register.
- There was not a comprehensive assurance system in place to monitor and improve performance. There was an audit schedule in place however not all audits were done regularly with some audits only being carried out once per year. The register manager could not be assured that patient outcomes were optimal as the clinic held no data on outcomes at the time of our inspection.
- Staff were clear about their roles and understood what they were accountable for. All procedures were consultant-led and the surgeon took overall responsibility for the patient.
- There were not robust processes in place for granting and renewing practising privileges. For example, the registered manager was not aware of which mandatory training courses had been undertaken and which level of safeguarding training medical staff had. However, all consultants who had been granted practising privileges had professional indemnity insurance in place. This was

checked when practising privileges were granted and renewed. The process of granting, checking and renewing practising privileges was being reviewed at the time of our inspection.

- There was no process in place for checking staff employment records. For example, the registered manager was not aware that some members of staff had an out of date disclosure and barring service (DBS) certificate.
- The registered manager had oversight of all procedures undertaken in the clinic. The registered manager observed procedures on an adhoc basis to review practice.
- The registered manager had never had an appraisal. They told us that they had received informal feedback but had never been invited to a formal appraisal.

Public and staff engagement

- Patients' views and experiences were gathered through patient satisfaction questionnaires, which could be completed in the clinic and online. Patient feedback was very positive.
- Staff feedback was gathered through staff meetings and annual staff satisfaction surveys. The 2017 staff survey was generally positive and there was a response rate of 90%. Key results showed most staff were satisfied or very satisfied with their relationships with patients, their working hours, and their working environment. Most staff were also satisfied or very satisfied with their manager, communication with their colleagues and the use of technology within their area of work. However, most staff were dissatisfied or very dissatisfied with their employee benefits, company-wide communication and were concerned about their job security.
- In response to staff feedback, a communications strategy was being developed and the company board had held discussions to address staff dissatisfaction with employee benefits.
- The registered manager told us they understood the value of raising concerns and encouraged staff to escalate their concerns too. Staff told us they felt comfortable raising concerns and escalating issues to the registered manager. They were actively encouraged to contribute to service improvements and their views were often sought.

Innovation, improvement and sustainability

- Staff had developed an eye drop chart, which was given to patients following cataract extraction. Patients could tick the chart to help them ensure they had not missed any dosages throughout the day.
- The registered manager was able to demonstrate a number of new processes, standard operating procedures and policies that had been implemented since commencing in post at the clinic. However, there was no governance support until more recently and this had been recognised as unsustainable.
- The company had recently employed a quality governance manager to help improve governance processes and develop policies to ensure they were relative to the clinic.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

The main service provided by this hospital was surgery. Where our findings on outpatients – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section.

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as **requires improvement.**

Incidents

- The recorded number of incidents was not broken down by the service into surgery or outpatients, so we were unable to see if any incidents had happened within outpatients.
- For our detailed findings on incidents, please see the safe section in the surgery report.

Cleanliness, infection control and hygiene

- See information under this sub-heading in the surgery section.

Environment and equipment

- Nursing staff and the healthcare assistant were enrolled on a competency-based programme for using specialist equipment in the consulting rooms. This was provided by the equipment manufacturers.
- Consulting rooms were well-equipped for nurse-led testing such as visual field analysis and ocular coherence tomography.
- For our detailed findings on environment and equipment, please see the safe section in the surgery report.

Medicines

- For our detailed findings on medicines, please see the safe section in the surgery report.

Records

- We were unable to review any patient records, as the clinic did not have a copy of patients' notes who attended outpatient appointments.
- See information under this sub-heading in the surgery section.

Safeguarding

- See information under this sub-heading in the surgery section.

Mandatory training

- See information under this sub-heading in the surgery section.

Assessing and responding to patient risk

- Consultants were supported by a registered nurse when giving treatment to patients, for example intravitreal joint injections.
- Nurses completed an intravitreal injection checklist. The checklist included which side the patient was having their injection, batch number, expiry date and ensured the consultant had checked the patient's details.

Requires improvement

Outpatients and diagnostic imaging

- Surgical patients who had their procedure performed elsewhere and only had their preoperative and postoperative appointments at the clinic, had all risk assessments completed where surgery had taken place.
- See information under this sub-heading in the surgery section.

Nursing staffing

- See information under this sub-heading in the surgery section.

Medical staffing

- Speciality consultants led the service. There was no locum usage.
- As all patients were seen for outpatient consultations, there were no handovers or shift changes.
- See information under this sub-heading in the surgery section.

Emergency awareness and training

- See information under this sub-heading in the surgery section.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

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

Evidence-based care and treatment

- See information under this sub-heading in the surgery section.

Pain relief

- Some consultants discussed natural pain relief remedies with patients and gave patients exercises they could perform at home to reduce pain.
- For our detailed findings on pain relief, please see the effective section in the surgery report.

Nutrition and hydration

- Patients were offered drinks when waiting in reception for their appointment.

Patient outcomes

- See information under this sub-heading in the surgery section.

Competent staff

- All consultants who offered outpatient appointments and treatment had undergone revalidation within the last five years with the General Medical Council (GMC). Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field and able to provide a good level of care.
- All consultants worked at an NHS trust and other private providers.
- For our detailed findings on competent staff, please see the effective section in the surgery report.

Multidisciplinary working

- See information under this sub-heading in the surgery report.

Access to information

- See information under this sub-heading in the surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was gained verbally for some outpatient treatments such as intravitreal joint injections. We were told by the registered manager that the consultants documented that patients had given consent in the records. We were unable to see any evidence of this because the clinic did not have a copy of outpatient records.
- For our detailed findings on consent, Mental Capacity Act and Deprivation of Liberty Safeguards, please see the effective section in the surgery report.

Are outpatients and diagnostic imaging services caring?

Requires improvement

Outpatients and diagnostic imaging

Good

We rated caring as **good.**

Compassionate care

- During our inspection, we did not speak with any patients who were attending an outpatient appointment. We did see some patients who were attending outpatient surgery pre and postoperative consultations. We also received 'share your experience' cards from patients who had attended outpatient appointments.
- For our detailed findings on compassionate care, please see the caring section in the surgery report.

Understanding and involvement of patients and those close to them

- See information under this sub-heading in the surgery section.

Emotional support

- See information under this sub-heading in the surgery section.

Are outpatients and diagnostic imaging services responsive?

Requires improvement

We rated responsive as **requires improvement.**

Service planning and delivery to meet the needs of local people

- The environment was appropriate for the services delivered. There was adequate comfortable seating, toilets, a water machine and a hot drinks machine for patients and their relatives waiting for their outpatient appointment.
- Car parking was very limited. The registered manager planned services to ensure there was not too many patients at the clinic at one time due to the limited parking facilities.
- For our detailed findings on service planning and delivery to meet the needs of local people, please see the responsive section in the cosmetic surgery report.
- See more detailed information under this sub-heading in the surgery section.

Access and flow

- Patients were offered appointments on weekdays, weekends and evenings depending on the availability of the consultant they wished to see.
- We observed an outpatient ophthalmology clinic running on time with no delays to patients' appointments.
- No audits took place of waiting times.
- For our detailed findings on access and flow, please see the responsive section in the surgery report.

Meeting people's individual needs

- See information under this sub-heading in the surgery section.

Learning from complaints and concerns

- See information under this sub-heading in the surgery section.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as **requires improvement.**

Leadership and culture

- See information under this sub-heading in the surgery section.

Vision and strategy

- See information under this sub-heading in the surgery section.

Governance, risk management and quality measurement

- See information under this sub-heading in the surgery section.

Requires improvement

Outpatients and diagnostic imaging

Public and staff engagement

- See information under this sub-heading in the surgery section.

Innovation, improvement and sustainability

- See information under this sub-heading in the surgery section.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure swab, needle and instrument counts are performed in line with national guidance.
- The provider must ensure controlled drugs are stored in line with Controlled Drugs (Supervision, management and use) Regulations, DH 2013 and NICE guideline NG46.
- The provider must have processes in place to ensure instruments are decontaminated and sterilised appropriately in line with HTM 01-01.
- The provider must ensure all staff understand the waste management processes in place.
- The provider must ensure theatres are deep cleaned every six months.
- The provider must ensure policies reflect the clinic's processes and services provided.
- The provider must have an exclusion and admission criteria in place.
- The provider must audit and monitor patient outcomes.
- The provider must ensure there are up-to-date records for each employee, including doctors working under practising privilege arrangements.

Action the provider SHOULD take to improve

- The provider should ensure verbal consent for treatment is recorded in all patient records.
- The provider should review the storage of sterile instruments.
- The provider should ensure consent forms are completed according to the fields on the consent forms and in line with the consent policy.
- The provider should consider developing an access to records to policy.
- The provider should ensure all staff, including medical staff are trained to the correct level of safeguarding adults and children.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2) (a) (b) (d) (e) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities 2014: Safe care and treatment)** **How the regulation was not being met:** Needle, swab and instrument counts were not completed prior to cataract surgery in line with accepted best practice guidelines, patient documentation and the clinic's own policy. Controlled drugs were not stored or managed in line with national guidance. Instruments were not always decontaminated appropriately. Not all staff understood and followed waste management processes. Theatres were not deep cleaned regularly.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1)(2)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance** **How the regulation was not being met:** Policies did not reflect the clinic's processes or the services provided.

This section is primarily information for the provider

Requirement notices

There was no clear exclusion and admission criteria in place.

Patient outcomes had not been analysed or audited.

Employment records were not always complete and up-to-date.