Consultant Eye Surgeons Partnership (Bristol) LLP

Quality Report

2 Clifton Park
Clifton
BS8 3BS
Tel:0117 9064214
Website:www.cesp.co.uk

Date of inspection visit: 6 July 2017 IMS3
Date of publication: 15/02/2018

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Inadequate

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

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

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

Summary of findings

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

Overall summary

South West Eye Surgeons LLP provides specialist eye treatments for adults and children and young people at their outpatient facility - Consultant Eye Surgeons Partnership (Bristol) LLP (the service). The service is in the process of changing its name and currently is registered with the CQC as Consultant Eye Surgeons Partnership (Bristol) LLP but is working under its parent name of South West Eye Surgeons LLP. The service provided care mostly to adults but also to a limited number of children and young people.

We inspected the whole service using our comprehensive inspection methodology.

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.

We rated this service as inadequate overall.

- There were limited systems and processes to provide oversight of the quality and safety of the services provided. The service did not have an oversight on safety, as there were no reliable systems and processes in place to monitor incidents, risk and performance.
- There were no official monitoring arrangements for consultants who worked at the service. Although all staff employed worked within a local NHS trust and were known to the partners, there was no evidence of training undertaken by staff or evidence of employment checks being carried out.
- There were no arrangements in place for granting practising privileges and reviewing employment checks and the content of all staff files lacked consistency.
- There was no evidence of how current evidence based guidance, standards, best practice and legislation was identified and used to develop the service.
- Records were not always maintained of medical photography.
- There was no evidence of how the provider and senior managers monitored and used current evidence based guidance, standards, best practice and legislation to develop the service.
- The outcomes of people's care and treatment were not always monitored regularly. There was limited documentation of audits carried out and no documentation of the discussion, learning or feedback.
- There was limited oversight that staff had the right training, only carried out surgery they were skilled for and had the correct employment checks.
- Staff did not receive regular appraisal or training and development opportunities.
- Quality did not receive sufficient coverage in executive meetings and was not documented in other relevant meetings. There was no evidence of performance monitoring or of assurance gained about the quality and safety of the service.
- There were no processes in place to review key items such as the strategy, values, objectives, plans or the governance framework.
- Leaders did not have the necessary experience or support to lead effectively. Leaders were not always clear about their roles and their accountability for quality

Summary of findings

We found good practice in relation to outpatient care:

- Staff said they felt able to report incidents although they had not had the need to do so. Most staff understood their responsibilities under the duty of candour.
- We observed good hand hygiene practice in clinical areas and patients confirmed this.
- During the reporting period, there were no incidences of healthcare-acquired infection. Medicines were stored securely.
- Patient records were secured, well maintained and clear to follow.
- There were sufficient staff on duty at the time of our inspection to meet patients' needs.
- Consultants and nursing staff understood the relevant consent and decision-making requirements of legislation and guidance. There was evidence that consent practices were in line with guidance and best practice.
- Patients were given the opportunity to take a period of reflection following a consent discussion and prior to surgery.
- Feedback from people who use the service, those who are close to them and stakeholders was positive about the way staff treated people.
- Patients were involved and encouraged to be partners in their care and in making decisions about their treatment and support.
- There were transparent and easy to understand pricing structures.
- Staff responded compassionately when patients needed help.
- Patients reported they had timely access to initial assessment, diagnosis and treatment. However, the provider did not monitor this.
- Patients had timely access to initial assessment, diagnosis and treatment.
- We observed good examples of care and treatment. Patients told us they felt supported and well cared for.
- Information was on how to make a complaint or raise a concern.
- Patient information could be provided in large print and Braille format.
- There was clear communication between multidisciplinary teams and administrative staff and external partners.
- No complaints had been made to the service.
- The organisation actively sought the views of patients and staff about the quality of the service provided.

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 one warning notice and four requirement notices. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals (Hospitals Directorate)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients and diagnostic imaging	Inadequate 	Outpatient services were the only service delivered at the location. We rated this service as inadequate overall because it was not safe, effective or well led. We rated caring and responsive as good.

Summary of findings

Contents

Inadequate

Consultant Eye Surgeons Partnership (Bristol) LLP

Services we looked at,
Outpatients and diagnostic imaging

Summary of this inspection

Background to Consultant Eye Surgeons Partnership (Bristol) LLP

Consultants Eye Surgeons Partnership (Bristol) LLP is a specialist eye service from an outpatient facility at 2 Clifton Park Bristol provided by South West Eye Surgeons LLP. Minor procedures, for example, lesion removal, biopsies and injections are provided at the service. If an operation is required, patients have surgery at the separately registered location of the CESP LLP - Bristol Eye Hospital which is run by the provider.

Consultants Eye Surgeons Partnership (Bristol) LLP are registered with the Care Quality Commission to deliver the following regulated activities:

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

A new manager was recently appointed and was registered with CQC in April 2017.

The outpatient facility had previously been inspected in March 2013 and January 2014, when all standards had been met.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one CQC inspector. The inspection team was overseen by Catherine Campbell, Inspection Manager and Mary Cridge, Head of Hospital Inspection for the South West.

Information about Consultant Eye Surgeons Partnership (Bristol) LLP

Consultants Eye Surgeons Partnership (Bristol) LLP was formed in 2003 and have an outpatient facility at 2 Clifton Park. The service offers long term management of ophthalmological conditions such as macular degeneration and pre and post-operative assessments for treatable conditions such as cataracts. Consultant Eye Surgeons Partnership (Bristol) LLP is a partnership of ten consultant eye surgeons who provide outpatient consultations and minor procedures from this location.

There are two consultation rooms, a treatment room (called the field room) and a waiting room as well as office space.

They employ a registered manager, a technician and seven administrative and secretarial staff who all are based at the site.

Patients can self-refer or can be referred by their GP or optician.

Activity (April 2015 to March 2016)

- During the reporting period of April 2016 to March 2017, 1843 patients were seen in the outpatient facility, 3.6% of these appointments were for children and young people.

The outpatient facility is registered to provide the following regulated activities:

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

During the inspection, we spoke with eight staff including, a technician, booking/ secretarial staff, the registered manager and four consultants. We spoke with four patients and one relative. During our inspection, we reviewed 11 sets of patient records.

There were no special reviews or investigations of the outpatient facility ongoing by the CQC at any time during the 12 months before this inspection.

Summary of this inspection

Track record on safety:

- There were no never events.
- There were no clinical incidents resulting in no harm, low harm, moderate harm, severe harm, or death.
- There were no serious injuries.
- There were no incidences of hospital acquired methicillin-resistant Staphylococcus aureus (MRSA).
- There were no incidences of hospital acquired methicillin-sensitive Staphylococcus aureus (MSSA).
- There were no complaints.

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?

Inadequate

We rated safe as inadequate because:

- The provider did not have a core set of safety checks when carrying out invasive procedures.There was no safety system, such as the World Health Organisation Surgical Safety Checklist, used prior to procedures being carried out to ensure patient safety.
- Medical photographs, which had been consented for, were not always stored in the patient record.
- There were no systems for granting practising privileges to consultants, although all were known to the partners and worked for a local NHS trust.
- Safeguarding was not given sufficient priority. There was no evidence that staff had received training in safeguarding either provided by the provider or a third party.
- Records of mandatory training carried out by staff were not complete. There were records which demonstrated some staff had completed mandatory training, but others such as those for consultants was not maintained. There was a record of the completion of basic life support for all consultants at the service.
- National infection control guidance was not followed, regarding the flooring in consulting areas where treatment may occur. There were carpets in place directly beneath trolleys where clinical procedures were carried out.

However:

- There were systems in place to report incidents and staff felt able to do so. There had been no incidents reported in the 12 months prior to the inspection.Most staff understood the requirements of the duty of candour.
- There had been no reported instances of healthcare acquired infection at the service and we observed good hand hygiene practice.
- The service appeared visibly clean and tidy. Handwashing facilities were available in all consultation and treatment rooms.
- Medicines were managed in line with legislation and best practice.
- Patients records were organised and easy to follow. They were written legibly and signed by the consultant.

Summary of this inspection

Are services effective?

Not sufficient evidence to rate

We did not rate effective, however:

- There was no evidence of how current evidence based guidance, standards, best practice and legislation was identified and used to develop the service.
- There was no oversight of the limited clinical audit programme at the weekly internal executive meetings. There was limited documentation of the audits carried out.
- The outcomes of people's care and treatment were not always documented so it was not clear whether the intended outcomes for people were always achieved.
- There was limited documentation to demonstrate that staff had the right training, only carried out surgery they were skilled for and were safe to practice.
- There were no arrangements in place for granting and reviewing employment checks and the content of all staff files lacked consistency.

Are services caring?

Good

We rated caring as good because:

- People were supported and treated with dignity and respect, and were involved as partners in their care.
- Feedback about the way staff treated people who used the service, those who were close to them and stakeholders was positive.
- Healthcare professionals at the service always introduced themselves to the patients in their care.
- People were involved and encouraged to be partners in their care and in making decisions about their treatment and support.
- Staff recognised the important role that relatives had in a patient's recovery or ongoing treatment.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility and choice was reflected with the service.
- The needs of different people were taken into account when planning and delivering services, for example on grounds of disability.
- Patients had timely access to initial assessment, diagnosis and treatment. Access to care was managed to take account of people's needs. Waiting times, delay and cancellations were minimal.

Summary of this inspection

- The appointment system waseasy to use and supported people to make appointments
- Information was provided in accessible formats before a patient's first appointment.
- Clear information was provided for patients should they want to make a complaint or raise a concern.
- However, it was not clear how improvements would be made or where this would be discussed, should a patient make a complaint.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- There were limited systems and processes to provide oversight of the quality and safety of the services provided. The service did not have an oversight on safety, as there were no reliable systems and processes in place to monitor incidents, risk and performance.
- There was limited awareness of the organisational vision and values.
- The arrangements for governance and performance management did not operate effectively. There was no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance at the service.
- Quality did not receive sufficient coverage in executive meetings and was not documented in other relevant meetings. There was no evidence of performance monitoring or of assurance gained about the quality and safety of the service.
- Leaders did not have the necessary experience or support to lead effectively. Leaders were not always clear about their roles and their accountability for quality.
- The governance framework and their arrangements and purpose were unclear. There was no process in place to review key items such as the strategy, values, objectives, plans or the governance framework.
- Staff at the service did not have a plan in place to develop, implement and monitor local safety standards for invasive procedures.
- There was minimal evidence of learning and reflective practice.

However:

- The organisation actively sought the views of patients and staff about the quality of the service provided.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Good	Inadequate	Inadequate
Overall	Inadequate	Not rated	Good	Good	Inadequate	Inadequate

Inadequate

Outpatients and diagnostic imaging

Safe	Inadequate
Effective	
Caring	Good
Responsive	Good
Well-led	Inadequate

Are outpatients and diagnostic imaging services safe?

Inadequate

Incidents

- There was an incident reporting system in place. Staff told us that incidents that occurred at the service, were reported on a paper based system, fed through to the registered manager and then issues and learning would be shared across the facility verbally or by email. No incidents had been reported and secretarial staff told us that they could not remember an incident happening in recent times and so could not share an example of how effective this system was.
- The incident reporting policy consisted of three lines, was unclear and did not provide guidance of which system to use.
- There were no never events, serious incidents or incidents reported in the 12 months prior to our inspection at the outpatient facility. 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. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents'andprovide reasonable support to that person. We spoke with two consultants who understood their responsibilities to patients; but could give no example of when they had applied the duty of candour. However, not all staff at the outpatient facility had an understanding of the regulation.

Cleanliness, infection control and hygiene

- There was a policy in place, which provided staff with information about infection prevention and control. However, it was generic and not tailored to the service. There were no audits undertaken to monitor infection control practice.
- There had been no reports of infection at the service.
- All areas of the service including the treatment room and consultation rooms appeared visibly clean and tidy. We were told all equipment was cleaned after every patient contact and again at the end of the day. The equipment stored in these rooms was covered to protect from dust. However, there were no cleaning task records or documented evidence of when the rooms or a piece of equipment had been cleaned.
- National guidance was not being followed, as there were carpets in all of the consultation rooms with the exception of the treatment/field room. The carpets appeared visibly clean and were free from stains. However, carpets were in place directly underneath trolleys where clinical procedures were carried out. There was potential for spillage of bodily fluid, which could not be cleaned from the carpet. As identified in

Health Building Guidance note 12 (HBN 12), in order to facilitate cleanliness and cleaning, flooring should be impervious, smooth and seamless and where possible hard flooring should be run up the walls for a short distance.

- We saw staff observing good hand hygiene practice. However, compliance was not monitored, as there were no hand hygiene audits available at the service.
- Handwashing facilities were available in consultation and treatment rooms. Personal protective equipment was also available for use.
- There were arrangements in place for the disposal of sharps and prevention of accidental injury or cross contamination, which were in line with best practice. The clinic rooms and the field/ treatment room had properly assembled sharps bins, which were labelled correctly and only filled to the recommended level.

Environment and equipment

- The service was provided in an old building over two levels. There was a treatment room (the field room) and two consultation rooms where care and treatment was provided.
- Disabled access and parking was clearly signposted and included in patient information packs sent out prior to appointments.
- We checked six pieces of equipment in the field room and saw that all services and calibration checks were up to date. Service records showed all pieces of equipment except one had an up to date service recorded.
- The classification, handling, labelling and storage of clinical waste kept people safe. Clinical waste was stored in a locked room and then removed by a private contractor, out of a designated exit at the back of the building.
- Adult resuscitation equipment was readily available and kept in the treatment room. Records for the checks on the equipment demonstrated that they were regularly completed. However, there was no provision of resuscitation equipment for children who attended the clinic.
- An independent laser safety officer had completed yearly checks on laser equipment and there was a stand-alone optical radiation policy and risk assessment. Only one consultant used the laser and a certificate showed they had completed a laser safety course.
- The laser room had a 'do not enter sign', black out curtains at the windows and the room could be locked from the inside. However, there was a silver coloured reflective bin located in the laser room, which had not been identified on the risk assessment. This was not in line with best practice as the Medicines and Healthcare products Regulatory Agency (MHRA) guidance recommends that all reflective surfaces be minimised in rooms where a laser is operated.
- The outpatient facility did not have step-by-step instructions to provide direction in the use of all equipment. There were no standard operating procedures (SOP) for equipment other than the laser, so efficiency and uniformity of performance was not assured.

Medicines

- Arrangements for managing the limited scope of medicines at the outpatient facility were in line with legislation and best practice. All medicines were stored in a locked cupboard in a locked room. Eye drops were ordered and delivered by a local pharmacy and kept in a locked cupboard or locked fridge and only administered by consultants or the optometrist.
- The fridge temperature had constant monitoring and if the readings went out of range than an email was sent to a member of staff for action to be taken. Staff showed us examples of these emails and told us what actions would be taken should a reading fall out of range for example; stock would be destroyed should the temperature drop below a certain range.
- There were arrangements for the safe practice of writing prescriptions. Consultants did not use prescription pads, but used headed paper and added their General Medical Council registration number alongside their signature. There were no facilities to dispense medicines on site and patients could take the prescription to a local pharmacy to obtain their medication.

- All medication changes were communicated by letter to the patients GP. Medical secretaries told us that this was important so they would make sure letters were sent out within two weeks.
- Patients were given leaflets with information about how to administer and look after their eye drops.

Records

- Patients' records were, organised and easy to follow, written legibly signed by the consultant and contained clinic letters, communications with patients and referral letters. However, patients' individual care records were not always maintained completely. We reviewed five sets of records for patients who had undergone minor plastic surgery. Each set of notes documented that pre-operative photographs should be taken during the outpatient appointment. Patients had signed consent for medical photography in line with Consultant Eye Surgeons Partnership (Bristol) LLP policy. However, only one set of notes had a photograph stored within it. Senior staff could not tell us where the photographs were kept if they were not in the notes. This was not in line with the General Medical Council guidance of making and using visual and audio recordings of patients, which states that "recordings made as part of the patients care will form part of the medical record."
- Patient records were stored securely at the service. However, the system for the transport of records between the service and the hospital where operations occurred needed improvement. Consultants transported patient records between the hospital and the outpatient facility and were held responsible for the safety and security of the notes, but there was no process or system to state how they were to be kept securely whilst in transit.

Safeguarding

- There was no provision of safeguarding training at the service and no records to demonstrate staff had undertaken training elsewhere. Senior staff told us that all consultants received training on safeguarding adults and children through their NHS training programme and they were verbally assured that this was correct. However, there were no records of this training maintained in the service. In 10 sets of consultant's personal files, only one contained an up to date overview of the completion of mandatory training. There was no evidence that safeguarding training had been completed at the correct level and was in date for all consultants that worked at the outpatient facility.
- There were nine staff members employed at the outpatient facility, not all had received safeguarding training. Three clerical staff members had not received safeguarding adults or children level one, which had been identified as mandatory training by the service.
- The secretarial/administrative and clinical staff told us that they had never experienced any safeguarding issues. Should they have any safety concerns regarding a patient they would contact the practice/registered manager who was the safeguarding lead.

Mandatory training

- The provider did not maintain a full record of the mandatory training completed by staff. There were no records to show which surgeons had received mandatory training in safety systems, processes and practices. Nine out of the 10 consultant files that we reviewed did not have evidence of any up-to-date completed mandatory training. However, there was evidence that all consultants had completed basic life support training, and the technician had completed intermediate life support training.
- There was a mandatory training programme for administrative staff, which covered health and safety and information governance. However, not all staff had completed the training programme. Five out of the nine staff employed had not completed the health, safety and welfare element or the information governance element of the training.
- A paediatric consultant and technician were the only staff members to treat children at the service. At the time of the inspection, the technicians' paediatric basic life support was out of date but senior staff told us an update had been booked. We were told that the consultants NHS appraisal gave the service assurance that all training was completed and in date. However, there were no documented expiry dates or records held by the service to demonstrate that this was correct.

- The registered manager had completed mental health awareness training. However, the technician who dealt with patients often on a one-to-one basis had not had training in mental health awareness or the Mental Capacity Act 2005.

Assessing and responding to risk

- Although only minor procedures were carried out at the service, there were no safety systems or processes in place to protect patients from procedures being carried out on the wrong site. Although there were no never events, serious incidents or incidents reported in the 12 months prior to the inspection, there was no system in place to provide a safe and consistent approach to avoiding patient harm. The service did not have a core set of safety checks when carrying out invasive procedures such as injections into the eye, excisions of lesions and class four laser treatments. They did not complete the World Health Organisations Surgical Safety Checklist for these local procedures and they had not developed their own set of local safety standards for invasive procedures to ensure safe practice across the outpatient facility.
- No routine observations were carried out on patients at the service, because of the nature of the procedures carried out.
- If a child received treatment and care at the service, the paediatric eye specialist consultant and the technician were the only staff that treated them. The technician had paediatric basic life support training but they required update training, which we were told, they were booked to attend but we were not supplied with a date.
- There were signs displayed in the treatment/field room informing people about areas where laser exposure was a risk. The service had yearly visits from the laser protection advisor. Staff said they could phone whenever advice was needed.

Nursing staffing

- The outpatient facility did not employ nursing staff but employed an ophthalmological technician, which was sufficient for the service. The technician worked alongside the consultant to assist in treatments, monitor outcomes and complete records.

Medical staffing

- The service engaged six partners and four associate partners. These consultant eye specialists delivered all the care and treatment at the outpatient facility under practising privileges.
- The provider did not have oversight or keep copies of references, specific safety checks such as Disclosure and Barring Service checks or registration with the General Medical Council (GMC). All consultants held substantive posts at a local NHS trust where, we were told, appraisals and recruitment checks had occurred but the provider had no record or assurance of this. No further proof other than a completed signed appraisal was required for consultants to practice at the service.
- The service did not employ any resident medical officers or agency staff.

Emergency awareness and training

- Should a patient become unwell staff would call for an ambulance. A recent incident demonstrated that staff took swift action, which led to a successful outcome for the patient.
- There was no backup generator at the service, but staff told us should a power shortage happen during the use of the laser it would stop working and would have to be re-calibrated prior to use. This was a safety feature, which ensured beams could not be misfired. If power continued to fail than another appointment could be made. At the time of our inspection this had never happened at the service.
- The service did not have a business continuity plan.

Are outpatients and diagnostic imaging services effective?

We did not rate effective.

Evidence-based care and treatment

- There was no evidence of how current evidence based guidance, standards, best practice and legislation was identified and used to develop the service. Policies and procedures in place were generic and were not tailored to the service.
- Senior partners told us that requests from consultant partners to undertake new clinical procedures, alerts from the Medicines and Healthcare Products Regulatory

Agency (MHRA), incidents, complaints, Royal College of Surgeons and National Institute for Health and Care Excellence (NICE) guidelines were discussed by senior staff and consultants during the internal executive meetings. We reviewed eight sets of internal executive meeting minutes and could see no record of these topics discussed and none were included as itemised topics on the agenda.

- There was an audit programme at the service, but there were no records of any audits having been carried. There was no oversight of the clinical audit programme at the weekly internal executive meetings. The audit programme did not contain a thorough breakdown of the information gathered, audits undertaken were not discussed, and actions from these were not identified. This did not demonstrate learning, improvement, or oversight of safety systems and processes.

Pain relief

- Senior staff told us that patients did not generally experience pain during the procedures offered at the facility. Patients were not offered analgesia routinely post procedure as treatments were only minor. However, should patients request analgesia then it could be prescribed by a consultant. Therefore, there were no audits of the effectiveness of pain relief provided.

Nutrition and hydration

- Food and drink was not provided at the service but patients had access to a coffee machine in the waiting room.

Patient outcomes

- Information about the outcome of patients care and treatment was not always collected and monitored. As a result, it was not clear whether the intended outcomes for patients were always achieved.
- The service kept a spreadsheet of surgical outcomes, which included pre- and post-operative care patients received at the outpatient facility. This included visual acuity, refraction and complications. They compared their expected refractive outcomes, visual acuity outcomes and posterior capsular rupture rates against the NHS National Ophthalmic Dataset (NOD). However, when we reviewed the spreadsheet we could see areas of missing data so we could not be assured that all the data was accurate and up to date.
- At the time of our inspection, they were in the process of registering with the Private Healthcare Information Network (PHIN). This independent, not for profit network helps patients make informed decisions about which care provider to access, the aim is to make sure all patients have access to trustworthy, comprehensive information on quality and price. All providers of private independent care in the UK are required by law to submit data to PHIN.
- During the reporting period of April 2016 to March 2017, there had been no unplanned transfers of care to other hospitals and no unplanned readmissions.

Competent staff

- The service had no documented scope of practice for their consultants. There was no record if staff had the right training and only carried out surgery they were skilled for and were safe to practice. There was no assurance that procedures in specialist areas were being performed, monitored or discussed at the weekly internal executive meetings.
- There were no arrangements in place for granting practising privileges and reviewing employment checks. Partners told us that they only employed consultants who had a substantive post as consultants at a local NHS trust. This job role and NHS yearly appraisal offered the assurances to Partners that the consultants were safe to practice. However, they did not follow their own human resources (HR) policy, which stated: “job descriptions, training, advertising for staff, annual appraisal, interview, bullying and harassment, practicing privileges and disciplinary issues are all up to date and issued to all staff. For this reason, strict employment policies are followed in ensuring that the employees are professionally qualified and fit for purpose to conduct their duties.”
- The human resources policy also set out what pre-employment checks and evidence would be required prior to a consultant surgeon joining the partnership. The policy stated that two references would be required, out of the ten files we checked we found only two contained references. All had an up to date

appraisal from the consultant's substantive post, however we found only one contained a Disclosure and Barring Service check (DBS) check. Nine out of the 10 files had a signed declaration statement by the consultant to say they had a DBS from their substantive NHS post but there was no evidence that the provider had checked this.

- The content of all staff files lacked consistency: records of General Medical Council fee confirmation to show registration were out of date; confidentiality agreements were not always signed or reviewed on the dates set; evidence of mandatory training was inconsistent. Out of 10 sets of files that we reviewed, only three had evidence of training undertaken.
- The appraisal rate for staff employed at the outpatient facility was difficult to ascertain. The audit schedule told us that all staff had their appraisal carried out yearly. However, the minutes of a one off team meeting in May 2017 documented that appraisal paperwork had been lost and that staff had not had an appraisal in three years.

Multidisciplinary working

- When it was identified that patients would require an overnight stay associated with their surgical procedure, secretarial staff booked a bed on Gloucester Ward at Bristol Eye Hospital. However, the process and agreement for this was not clear and was not identified within the service level agreement in place with the NHS trust.
- Secretarial staff told us that as the majority of patients were ambulatory and only having day case surgery referrals to other multidisciplinary teams did not happen. If a referral was required then hospital staff would make this following their procedure. However, secretarial staff could not give an example of when this had happened.

Access to information

- Staff at the service did not always have all the information they needed to deliver effective care and treatment. Patient records contained referral letters, clear communications and documentation of operations. However, in four out of five sets of records we reviewed the patient's medical photography was missing.
- Discharge letters were posted to GPs within two working days, the secretaries told us that it was important to update GPs of any long-term medication change. However, this process was not monitored so we could not be assured that this always happened in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed five sets of notes for patients undergoing treatment. Informed discussions were held prior to a patient signing the consent form and in advance of the scheduled operation day.
- The registered manager had completed mental health awareness training. However, the technician who dealt with patients often on a one to one basis had not had training in mental health awareness or the Mental Capacity Act 2005.
- Secretarial staff had not had training in mental health awareness and told us if they spoke to patient who appeared to be having difficulty than they would escalate this to the registered manager. However, they could not give us an example of when this had happened.
- We spoke with two consultants who explained what they would do should they have a patient who lacked mental capacity require consent for example have a best interests meeting. However, they could not give an example of when this had happened to a patient attending the service.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- Feedback about the way staff treated patients was positive. We observed that patients were treated with respect and kindness during all interactions with staff. Relationships between patients and staff were positive. Patients told us they felt supported and well cared for.

Inadequate

Outpatients and diagnostic imaging

- We spoke with four patients and one relative who said that privacy and confidentiality was respected at all times.
- Healthcare professionals introduced themselves to the patients in their care. Staff explained their roles and responsibilities when they met patients for the first time and continued to do so throughout their treatment.

Understanding and involvement of patients and those close to them

- People were involved and encouraged to be partners in their care and in making decisions about their treatment and support. Staff spent time talking to patients and their relatives. Patients had the opportunity to have their partners attend their appointments and ask questions. Staff recognised the important role that relatives had in a patient's recovery or ongoing treatment.

Emotional support

- Staff greeted patients as they entered the building and appointments were carried out in private rooms. However, we did witness a member of staff walk into a private consultation with out knocking.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

- The environment at the service was patient centred. There were comfortable chairs in the waiting rooms of different heights for those with mobility issues. Patients and visitors could purchase drinks from a machine in the waiting room. Children could access a selection of books in a designated area. There was good access for disabled patients to access the outpatient facility and a disabled parking space was available. Patients could request a T-Loop hearing aid at reception.

Access and flow

- Patients had timely access to initial assessment, diagnosis and treatment. If a patient required an emergency appointment post procedure then they would be seen either at the service or at CESP LLP at Bristol Eye Hospital. If a situation was deemed a medical emergency, then the patient was told to attend the local accident and emergency unit.
- Referrals for consultations came from the GP or patients could self-refer. Appointments were booked within three weeks. Secretarial/booking staff told us they aimed to provide an initial appointment within two weeks.
- Senior staff told us they did not audit waiting to access treatment times. However, we spoke with four patients who told us that the service had been quick, efficient and responsive. One patient told us they had they had received an appointment within three weeks and one patient managed to fit their appointment around their holiday.
- There were no cancelled appointments during the reporting period of April 2016 to March 2017

Meeting people's individual needs

- Reasonable adjustments were made and action was taken to remove barriers when people found it hard to use or access services. Facilities at the service were well set up for people with disabilities.
- Consultations could either be at the service or if a patient requested at the provider's other location at the Bristol Eye Hospital. This was clearly set out in the Patient Guide. Appointments could be requested on a Saturday if patients were not able to attend during normal clinic hours. The care pathway used by the service stated that when necessary staff should consider contacting a translator. We were told that any translation services were pre-booked by the secretaries.
- Secretarial staff at the service liaised with colleagues in the provider's other location in advance if a patient who lived with dementia, a learning disability, or with mental health problems required surgery. When necessary, the staff at the other location would make any onward referral for internal or external services for patients with additional needs, such as occupational therapy or district nursing.
- Information was provided in accessible formats before a patient's first appointment. Patients received

information about the different pricing structure for self-pay and insurance pay. A pack was provided which included information about what to bring to the first consultation, parking and what to expect during the appointment.

- Patients told us that information leaflets, which the service provided, were useful clear and easy to understand.

Learning from complaints and concerns

- Clear information was provided for patients should they want to make a complaint or raise a concern. Complaints leaflets were available and the process of making a complaint was described in the Patient Guide, which all patients were sent prior to consultation and treatment.
- The provider had a complaints policy, which had been reviewed within the 12 months prior to our inspection. The organisation had received no formal complaints between April 2016 and March 2017.
- The organisation actively sought the views of patients and staff about the quality of the service provided. The service aimed to answer any complaints within a 24-hour time period. We were told they had received no complaints between the reporting period of April 2016 to March 2017 so we did not see any examples of complaints in the meeting minutes. We were told that any complaints would be discussed at the weekly internal executive meeting but this was not a standard agenda item.

Are outpatients and diagnostic imaging services well-led?

Inadequate

We rated well-led as inadequate

Leadership and culture of service

- There was a registered manager who reported to the executive committee of partners. The registered manager was also the registered manager for the provider's separately registered surgical facility (CESP LLP at Bristol Eye Hospital).
- The registered manager was new to this role. At the time of our inspection, the registered manager had received limited support, development or direction from the executive committee and nominated individual, to deliver the role. At the time of our inspection, they had no development or training programme in place for the registered manager.
  We spoke with secretarial and clinical staff at the service, all of whom praised the open door policy of senior staff. Staff said they had a good working relationship with consultants at the service.

Vision and strategy for this core service

- There was a statement of vision and guiding values, which were: to understand and exceed the expectations of patients; encourage all team members to participate in achieving our aims and objectives; and, to invest in equipment and technology. However, some senior staff they were not aware of the organisational vision and values.
- The minutes of the executive meetings did not set out a clear strategy, which was monitored and reviewed on a regular basis.

Governance, risk management and quality measurement

- There was no effective governance framework and the governance arrangements and purpose were unclear. The provider could not ensure that responsibilities were clear and that quality, performance and risks were understood and managed. There were no processes in place to review key items such as the strategy, values, objectives, plans or the governance framework at the hospital.
- There was no documentary evidence of the audit programme therefore they did not have assurance of the quality or safety of care provided or processes to ensure continuous improvement.
- There was no oversight of the processes for engagement of staff via practising privileges or otherwise and no oversight of the mandatory training completed by staff.
- Comprehensive risk assessments and management plans were not always carried out for those patients who used the service. The risk register in the service did not reflect the objectives, risks and controls for the whole organisation. The risk register contained two

risks, neither of which contained an audit trail, an accountable individual responsible for managing any actions or any quantification or ranking of risk. There was no analysis or plan of how risks should be treated and no discussion, evaluation or oversight of any risk at the weekly internal executive meetings.

- Staff at the service did not have a plan in place to develop, implement and monitor local safety standards for invasive procedures using the National Safety Standards for Invasive procedures (NatSSIPs) framework. These set out the key steps necessary to deliver safe care for patients undergoing treatment. The World Health Organisation (WHO) surgical safety checklist was not used.
- There was no assurance that the provider monitored and reviewed the surgical procedures that its consultants carried out at the service. Weekly internal executive meeting were held, but these covered financial issues, car parking and machine service updates. Although there were no terms of reference, we were told that this forum was used as a medical advisory committee and clinical governance group. However, there was no evidence within meeting minutes that demonstrated this occurred. We reviewed eight sets of meeting minutes and could not see evidence of discussions around surgical procedures, NICE guidelines or MHRA alerts.
- All of the consultant partners and associate partners working for CESP (Bristol) LLP – Bristol Eye Hospital held indemnity insurance in accordance with the HealthCare and Associated Professions Indemnity Arrangements Order 2014.

Public and staff engagement

- The patient satisfaction survey results were collated for the period between January 2016 and December 2016. Patients were asked 10 questions about their arrival at the hospital, the facilities, cleanliness, staff and overall recommendations of the service. Scores were lowest on the overall level of comfort, particularly around the food/snack offered. We could not see any discussion of this in the executive meeting minutes.
- The provider developed their own patient information leaflets for a range of treatment and conditions. Options for large print and braille were offered and the emergency 24-hour phone number was clearly displayed.

Innovation, improvement and sustainability

- The provider told us they invested in the most up to date technology software and lens database in order to deliver accurate results. They had recently invested in optical coherence tomography to speed up diagnosis and reduce the need for invasive retinal investigation.
- There was little innovation or service development and minimal evidence of learning and reflective practice.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is an effective governance framework and processes and systems in place so as to ensure: they have oversight of service provided; the quality and safety performance is monitored; there is oversight of the safety of the environment and equipment in which care is delivered; care is delivered in line with evidence based guidance and best practice; and risks to patients are identified, assessed and monitored consistently.
- The provider must ensure that a clear incident reporting system is in place, and that learning from incidents is identified and feedback is provided to staff.
- The provider must ensure that all staff employed, including partners and senior staff, have the qualifications, competence, skills and experience to undertake their role. This should ensure that employment checks are in place and their scope of practice is also clearly identified and agreed.
- The provider must ensure that all staff employed receive regular mandatory training and other training opportunities pertinent to their role.
- The provider must ensure that all staff receive an appraisal.
- The provider must ensure that systems and processes for the safeguarding of adults and children are clear and staff have received training in them.
- The provider must ensure that the premises and equipment used to provide care and treatment to patients is safe for such intended use.
- The provider must ensure that medicines are administered following clear authorisation either via a prescription or using a patient group direction.

Action the provider SHOULD take to improve

- The provider should put steps in place to make sure that the registered manager has the support and develops skills necessary to run the service.
- The provider should make sure that records of medical photography are maintained.
- The provider should make sure that information about patient outcomes is submitted.
- The provider should consider the removal of carpets in areas where clinical procedures are performed.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 19: Fit and proper persons. 19(1) Persons employed for the purposes of carrying on a regulated activity must— 19(1)(a) be of good character, 19(1) (b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. 19(1) (c) be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed. 19(2) Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in (a)Paragraph (1), or (b) In a case to which regulation 5 applies, paragraph (3) of that regulation. How the provider is in breach of the regulation: The provider did not have clear records to demonstrate that the people employed for the purposes of carrying on the regulated activity were of good character; had the qualifications competence, skills and experience necessary for the work performed; were able by reason of their health to undertake the tasks they were employed to do so; or to demonstrate that they had effective recruitment procedures established and operating effectively.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18: Staffing 18(2) Persons employed by the service provider in the provision of a regulated activity must - 18 (2)(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, 18 (2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, How the provider is in breach of the regulation: The provider did not ensure that all staff received ongoing mandatory training, supervision or appraisal to enable them to carry out the duties they are required to perform. There were not systems in place to enable staff to obtain further qualifications appropriate to the work that they performed. The registered manager had not been provider with support, training or development opportunities to develop skills, confidence and competence in the role.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 13: Safeguarding service users from abuse and improper treatment 13(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. 13(2)Systems and processes must be established and operated effectively to prevent abuse of service users

This section is primarily information for the provider

Requirement notices

How the provider is in breach of the regulation:

Staff did not receive training in safeguarding adults or children and there were no clear systems in place within the service for the reporting of safeguarding.

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12: Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users. 12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include; (a)Assessing the risks to the health and safety of service users receiving the care or treatment; (b) Doing all that is reasonably practicable to mitigate any such risk. (c) Ensuring that person providing care and treatment to service users have the qualifications, competence, skills and experience to do so safely. (d) Ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. (e) Ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. How the provider is in breach of the regulation: The provider did not have oversight of the risks to the health and safety of those receiving care and had not ensured that there were actions in place to mitigate such risks. They did not have a system in place to ensure that those providing care and treatment to patients had the qualifications, competence, skills and experience to do so safely. There was no ongoing oversight of the safety and maintenance of the premises or equipment.

This section is primarily information for the provider

Enforcement actions

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 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17: Good governance 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part 17(2)Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to-- 17(2) (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). 17(2)(b) Assess monitor and mitigate the risk relating the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. 17(2)(d) maintain securely such other records as are necessary to be kept in relation to— 1. persons employed in the carrying on of the regulated activity, and 2. the management of the regulated activity; 17(f) evaluate and improve their practice in respect of the processing of the information referred to in (a) (b) and (d). We have told the provider that they must put systems and processes in place to ensure they have oversight and assurance of: The quality and safety of the service, including: the recruitment of staff and partners; incident reporting,

This section is primarily information for the provider

Enforcement actions

investigation and learning; risks to patient safety including those related to the environment and equipment; policies and procedures in place to enable audit of practise; the maintenance of records relating to persons employed in the carrying on of the services and the management of the regulated activities carried out by the provider; and, processes and systems to enable the evaluation and improvement of practise in respect of the processing of information relating to governance.