Face & Eye

Quality Report

Manchester Eye and Cosmetic Clinic Limited
Face and Eye Clinic
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Date of inspection visit: 10 October 2017 to 11 October 2017 and an unannounced inspection on the 19 October 2017.
Date of publication: 27/12/2017

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

Ratings

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

Overall summary

Face and Eye Clinic is operated by Manchester Eye and Cosmetic Clinic Limited. The facilities include a reception with a comfortable chaired area, one operating theatre, three consulting rooms, one diagnostic room, one treatment room/laser room and four day case chairs in the post-operative discharge area.

The service provides surgery and outpatients. We inspected surgery and outpatient services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 10 October 2017, along with an unannounced visit to the service on 19 October 2017.

Summary of findings

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 clinic was surgery. Where our findings on surgery for example, management arrangements also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

Services we rate

We rated this service as good overall.

We found good practice in relation to surgical care:

- There were systems in place to protect patients from avoidable harm and learn from incidents.
- The service was visibly clean and well maintained. There were systems in place to prevent the spread of infection.
- There were effective systems in place to ensure that equipment was safe and ready for use.
- There were effective arrangements in place to ensure staff had, and maintained the skills required to do their jobs.
- Care was delivered in line with national guidance and outcomes for patients' were good.
- The service had developed local safety standards for invasive procedures which included the use of the World Health Organisation checklist (WHO) for all surgery performed. The use of the WHO checklist ensures the correct procedure is competed on the right patient.
- There were arrangements for obtaining consent ensuring legal requirements and national guidance was met.
- The individual needs of patients were taken into account to ensure patients received safe care and treatment
- Patients' could access care when they needed it and were treated with compassion. Their privacy and dignity was maintained at all times.
- The service management team had the confidence of patients and their team. Staff felt motivated and supported by the management team.

We found good practice in relation to outpatient care:

- The reception area was clean, modern and bright and provided ample seating for patients to sit and relax.
- We saw that patients were greeted by professional reception staff on arrival at the clinic.
- Patients were encouraged to complete patient surveys so the service could learn from their feedback.
- There was hot and cold drinks on offer for all patients who attended the clinic.
- Patients did not have to wait long following arrival before being seen by their consultant.
- There was a booking system in place to ensure patients were seen in a timely way from referral to treatment.
- There were safety procedures in place for the use of the laser.
- There were procedures in place to support patients who requested a chaperone during their consultation.

However, we also found the following issues that the service provider needs to improve:

- Access to the theatre was not secure which did not comply with Health Building Note (HBN) guidance.
- There was not a formal meeting structure in place for a Medical Advisory Committee to ensure that the medical team were regularly updated as to their performance and review their outcomes for their patients.
- There was no assurance system that all the staff had read and signed they had understood policies, procedures and risks associated with the clinic or their areas of responsibility as policies and risks were updated.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	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. We rated this service as good because it was safe, effective, caring, responsive and well-led. There was a system in place to record incidents and investigations took place which identified learning that was shared across the clinic. All areas of the theatres and wards were clean and free from hazards. Infection screening of patients took place. Records were accurately documented in line with the organisation policy and were securely stored. Staffing levels were planned and adequate to meet the needs of the patients. There was a 24 hour on-call system to ensure patients could access support once they had returned home. The service used care pathways that had been developed for staff to follow to ensure patients received safe care and treatment. Staff treated patients and relatives with dignity and compassion. The friends and family test and patient satisfaction surveys showed positive results. All staff spoke positively about management staff and felt well supported.
Outpatients and diagnostic imaging	Good	Surgery was the main activity of the service. Where our findings relate to both activities, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well led. The outpatient department was visibly clean and there was evidence of cleaning schedules and handwashing audits being completed. Reception staff were polite and professional and welcomed patients as they attended their appointment. Patients did not have to wait long before being seen by their consultant.

Summary of findings

Safeguarding systems were in place and safeguarding considerations had been taken into account in the pre-operative assessment process.
Compliance with mandatory training was good and staff had regular appraisals and there were training opportunities available.
Patients said that staff were caring and respected their privacy and dignity.
There was strong leadership and a culture to continuously improve services and patient care.

Summary of findings

Contents

Good

Face and Eye Clinic

Services we looked at

Surgery and Outpatients and diagnostic imaging

Summary of this inspection

Background to Face & Eye

Face and Eye Clinic is operated by Manchester Eye and Cosmetic Clinic Limited. The service opened in 2007. It is a private clinic in Northenden in South Manchester that provides services to adults. The clinic does not provide any services to children. The clinic primarily serves the communities of the Manchester area. It also accepts patient referrals from outside this area.

The clinic has had a registered manager in post since May 2011.

Face & Eye offered a range of treatments and surgery for conditions such as cataracts (a medical condition in which the lens of the eye becomes progressively opaque, resulting in blurred vision), upper and lower lid blepharoplasty (plastic surgery operation for correcting defects, deformities, and disfigurations of the eyelids; and for aesthetically modifying the eye region), Ptosis (drooping or falling of the upper eyelid), excision biopsy of lesions, xen stent (a surgical implant designed to lower high eye pressure), Mohs reconstruction (Mohs reconstructive surgery helps to restore facial structures that had defects in them), ectropion repair (when the lower eyelid turns outwards), Intra-vitreal injections (injection of medicine into the vitreous, near the retina at the back of the eye), and laser surgery.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,and a CQC inspection manager. The inspection team was overseen by Nicholas Smith, Head of Hospital Inspection.

Information about Face & Eye

The clinic provides day case surgery and does not have any overnight beds. The service operates between the hours of 8am to 6pm from Monday to Friday.

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures (17 March 2011)
- Surgical procedures (17 March 2011).
- Treatment of disease, disorder or injury (9 May 2011).

During the inspection, we visited the outpatient department and surgical areas. We spoke with seven members of staff including; registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with five patients and one relative. We also received 11 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed a total of 12 sets of patient records.

There were no special reviews or investigations of the clinic ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice, and the most recent inspection took place in December 2013, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (April 2016 to March 2017)

- In the reporting period April 2016 to March 2017, there were 361 day case episodes of care recorded at clinic; of these 14% were NHS-funded and 86% other funded.
- The service performed 102 cataract surgery, 32 Lower lid blepharoplasty, 32 upper lid blepharoplasty, 29 Ptosis surgery, 28 excision biopsy of lesions, 20 xen stents, 16 mohs reconstructions, 16 ectropian repairs, 13 intra-vitreal injections, and 13 laser surgeries. Surgical procedures were performed under local anaesthetic or conscious sedation.

Summary of this inspection

- There were 1002 outpatient total attendances in the reporting period; of these 91% were other funded and 9% were NHS-funded.
- There were18 doctors working at the clinic under practising privileges, three of which were directors of the service.
- The service employed a registered manager, a theatre manager, an administration manager, a healthcare assistant, three receptionists and an administration assistant. There was a bank of other professional that were used on a regular basis to ensure adequate staffing of the clinic. The bank staff included four registered nurses an operating department practitioner (ODP) and healthcare assistants.

Track record on safety (April 2016 to March 2017).

- No never events.
- No reported clinical incidents or non-clinical incidents.
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA).
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA).
- No incidences of hospital acquired Clostridium difficile (C.diff).
- No incidences of hospital acquired E-Coli.
- Five complaints in the reporting period (April 2016 to March 2017).

Services provided at the hospital under service level agreement: These included

- Laundry
- Employment Law and Health and Safety Support
- Pharmacy
- Buildings maintenance
- Laser protection service
- Electrical maintenance
- Equipment sterilisation
- Emergency transfer agreement with a local trust

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?

Good

We rated safe as good because:

- There were effective processes in place to protect patients and staff from acquiring an infection whilst receiving treatment at the clinic. This included schedules of cleaning with oversight from managers to ensure compliance.
- There were systems and processes in place to ensure that the premises and equipment used by the service were clean, secure, maintained and suitable for the purpose for which they were being used.
- Records were accurate, secure and complete for every patient who attended the clinic for surgery.
- Risks to patients were assessed and monitored at pre assessment, and then checked again prior to treatment.

Are services effective?

Good

We rated effective as good because:

- The service had developed local safety standards for invasive procedures which included the use of the World health Organisation checklist (WHO) for all surgery performed.
- The service had developed pathways to ensure that patients received safe care and treatment which included all the necessary information for the staff to follow prior to and following a surgical procedure.
- The service provided input into the consultant annual appraisal which included the surgeries performed, patient satisfaction and complaints.
- We saw that staff gained consent to treatment and this was documented fully in all the records we reviewed.

Are services caring?

Good

We rated caring as good because:

- We saw that staff treated patients with dignity and respect at all times and all patients we spoke with confirmed this.
- Staff were polite friendly and helpful in their approach.
- We reviewed 43 clinic feedback comment cards received from July to September 2017. All feedback was highly complementary regarding the staff and the level of service received at the clinic.

Summary of this inspection

- The service participated in the friends and family test and asked patients to complete patient satisfaction questionnaires. The response levels and patient satisfaction scores were high.

Are services responsive?

Good

- Patients accessed care and treatment at a time to suit them. Patients we spoke with told us they were given a choice of dates for their procedure, and reported they did not wait long for their surgical procedure to take place.
- There were no cancelled procedures for non-clinical reasons in the reporting period from April 2016 to March 2017.
- All clinic areas were wheelchair accessible, and there was a bathroom which had been adapted for patients with mobility difficulties.
- The service received low numbers of complaints.

Are services well-led?

Good

We rated well-led as good because:

- There was a vision and strategy plan for 2016- 2019 to shape the direction of the organisation.
- There was a process in place to assess, monitor and mitigate risks relating to the health and safety and welfare of the patients and staff.
- There were policies and procedures to govern the operation of the organisation which had been reviewed and were in date.
- Staff were positive about their relationships with their immediate managers.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

Good

Surgery

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

Are surgery services safe?

Good

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

We rated safe as **good.**

Incidents

- There were processes in place to record, monitor, assess and learn from incidents that occurred at the clinic. Incidents were graded from no harm through to severe. The process was supported by policies and procedures to provide staff with a structure to follow in the event of an incident occurring. Staff were aware of what constituted an incident and were aware of incidents that had occurred within the clinic.
- We reviewed the incident policies and which outlined the procedure to follow and saw that the policies contained flow diagrams to aid in following the correct process.
- The service reported there were no serious injuries and no never events in the reporting period from April 2016 to March 2017. 'Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. 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.'
- From April 2015, all providers were required to comply with the Duty of Candour Regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were aware of the duty of candour regulation; ensuring patients received a timely apology when there had been a defined notifiable safety incident. We saw the organisation incident policy referenced duty of candour.
- Following an investigation from a needle stick incident we saw that a reflective practice had been completed to learn and share the latest NICE guidance in managing sharps and needle stick injuries. We saw that this learning was shared across the organisation.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The service monitored and recorded patient risk of developing a pressure sores. Patients were screened and their waterlow score documented in their patient records. The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore in a given patient.
- The service routinely assessed patients for thromboembolisms (VTEs). VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients. Information provided by the service showed that in the reporting period from April 2016 to March 2017, 100% of patients were assessed for VTE. We saw in theatre there were disposable compression boots for those patients considered at risk

of developing a blood clot who were undergoing surgery for more than one hour. Compression boots prevent deep vein thrombosis (blood clots in legs) during surgery.

- A falls audit was completed in January 2017; the audit consisted of an environmental inspection and interviews with staff to look for any potential areas within the environment where falls could occur. The audit found all areas of the clinic were deemed safe and there had been no falls at the clinic in the past 12 months.

Cleanliness, infection control and hygiene

- There were processes in place to protect patients and staff from acquiring an infection whilst receiving treatment at the clinic. There was a policy and procedures for staff to follow, and staff were aware of their roles and responsibilities to minimise the occurrence of infection. This included schedules of cleaning with oversight from managers to ensure compliance.
- Data provided by the service showed that between April 2016 and March 2017 there had been no reported cases of MRSA and MSSA at the clinic. MRSA and MSSA are infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated.
- We saw that staff used an Aseptic Non Touch Technique (ANTT).This minimises the occurrence of infection transmission between patients. Aseptic technique is used during clinical procedures to prevent microbial contamination of aseptic parts and sites by ensuring that they are not touched either directly or indirectly.
- The service completed aseptic technique audits to ensure compliance from all staff and surgeons. We saw that the audits completed involved observing the practice of all staff including consultants and health care staff to ensure that aseptic technique guidance was being followed. Findings from the audits showed 100% compliance with aseptic non touch technique.
- Infection control audits were completed routinely as part of an audit schedule. The audit was undertaken yearly by an external infection prevention and control nurse. Results found the clinic was compliant in areas of the audit. This included, staff training, cleanliness, waste management and policy and procedures.
- The clinic had an infection control link nurse to support and advise the service to ensure that infection control principles and organisational polices for infection control were adhered to.
- We saw Personal Protective Equipment (PPE), and hand sanitising gel was available across theatres and outpatient areas including at the entrance to the building.
- In theatres the staff wore disposable gowns, and all disposable gloves were latex free to protect those patients who had a latex allergy.
- Hand hygiene audits were completed to ensure compliance with hand washing. All staff were observed to ensure they had a correct hand washing technique and to highlight the areas missed. Results from the audits we reviewed for March 2017 showed 100% of staff adhered to good hand hygiene principles. We also observed that staff adhered to good hand washing principles.
- The service monitored surgical procedures to ensure patients were infection free following surgery. The information provided by the service showed in the reporting period from April 2016 to March 2017 there had been no surgical site infections.
- There were daily cleaning schedules for all theatre areas and we saw that these had been completed. All areas were visibly clean and tidy and maintained to a high standard. Staff confirmed that managers of the service had oversight to ensure the environment remained clean and tidy throughout the day. We observed during the inspection that all areas of the clinic remained clean throughout the day and 'I am clean' stickers were used to denote the toilets and consulting rooms were clean and ready for use.
- In theatres, most of the surgical instruments were single use only. We saw that all surgical instruments were prepacked, dated and kept in a designated area within the theatre. We saw all storage units were clean and the stock rotated.
- Surgical instruments that were re-usable were packaged and sent for decontamination. We saw that these were stored separately when used and were kept moist in line with the Department of Health technical memorandum on decontamination.
- Extra sets of surgical instruments were kept to ensure the continuity of surgery if a set was to be deemed unusable.

- We saw in theatres there was a separate area for staff to wash their hands in readiness for surgery. We saw that water taps were touch free to minimise the risk of cross contamination.

Environment and equipment

- There were systems and processes in place to ensure that the premises and equipment used by the service were clean, secure, maintained and suitable for the purpose for which they were being used.
- The clinic was a two storey building with all facilities needed for the treatment of patients housed on the ground floor. This included the consultation rooms, laser facility and bathrooms.
- Access to the clinic was controlled and patients were required to press a call bell to gain access to aid security and patient privacy.
- There were bathroom facilities suitable for patients who required a wheelchair. We saw that the bathroom had grab rails to aid independence.
- There was one operating theatre at the clinic, with a recovery area and a separate discharge area for patients to sit whilst waiting to be discharged. We observed that patients in these areas were monitored to ensure patient safety.
- Access to the theatre was not controlled via a locking system to maintain security and minimise the occurrence of an unauthorised person walking into the area. This was not compliant with best practice guidance within the Health building note (HBN 26), facilities for surgical procedures that states secure doors are essential between the main entrance lobby and operating theatre. We raised this with the service managers at the time of inspection.
- All seating in the waiting and discharge areas were clean and free from staining.
- All floor coverings were easy clean and in good repair.
- Lighting in the clinic was bright and all in working order.
- Offices not in use were kept locked to maintain security.
- We saw evidence of six-monthly internal and external environment checks by the registered manager to ensure the building and external areas were safe for patients and staff to use. The report contained notes for any remedial actions to be completed.
- The service kept a record of all equipment in use at the clinic. Each item had a separate risk assessment and a risk assessment log kept of when the assessment needed to be reviewed. We saw that all equipment risk assessments were in date.
- There were easy use guides for the machinery being used at the clinic to aid new staff. The guides provided pictures of the equipment to aid learning.
- There were local rules for the use of the laser and a risk assessment for its use. The local rules provide guidance on the safe use of lasers. The local rules contained methods of safe working practices and listed those staff who were authorised for its use with details of the Laser Protection Supervisor (LPS) and Laser Protection Advisor (LPA).
- We saw that the LPA had completed a site visit in May 2017 to examine the laser treatment room and process. The room and the location of the laser was deemed appropriate for use.
- The laser room had an illuminated warning sign outside the room and a lockable door. This ensured patient and staff safety to avoid accidental exposure to the laser. We observed that the door was kept locked when not in use and the keys for the laser were kept in a locked cupboard to prevent unauthorised use.
- The laser room had no windows or reflective surfaces to reduce the risk of the redirection of the laser beam during treatment.
- Eye protection was available for those staff or persons present in the laser treatment room. This reduces the risk of accidental exposure to the laser.
- We saw that service logs were kept for equipment being used at the clinic. Equipment was maintained by external sources to ensure equipment functioned as to the manufacturer's recommendations. We saw that the Phacoemulsification machine and the operating chair were due for servicing in September 2017 and had not been completed. However, we saw that servicing was planned to take place in October 2017. We saw there was a plan in place to ensure regular timely servicing of equipment.
- We saw there was routine yearly electrical equipment safety testing. This is a process by which electrical appliances are routinely checked for safety. Records indicated that equipment had been tested appropriately to ensure that it was safe to use.
- There was an emergency generator in theatres to provide power in the event of a power failure.

- Records indicated that resuscitation equipment for use in an emergency in the operating theatre was regularly checked and documented as complete and ready for use. The trolley was secured with tags, which were removed and replaced following routine checking of the contents of the trolley. We saw that the resuscitation trolley had been consistently checked over the past three months.
- We saw that service stored oxygen in a stock area within theatre. We were told that two spare oxygen cylinders were kept at all times to ensure adequate supply.
- A portable lifeline oxygen and face mask was kept in a grab bag for emergency use within the clinic and outpatients area.
- We saw in theatres there was spare equipment for if equipment failed. We saw that there was more than one syringe driver to deliver intravenous sedation or pain relief. We observed in the servicing records that they had been serviced in 2017.
- Daily morning surgical meetings were held to ensure that all staff had the required equipment for the surgeries planned for that day.
- We observed that all stocks, for example sutures, were in date and the stock was rotated to ensure the stock with the shortest expiry date was used first.
- There was a process in place to alert or receive notifications from the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA ensures that medicines, medical devices and blood components for transfusion meet applicable standards of safety, quality and efficacy. The theatre manager checked equipment and devices to ensure that any alerts concerning any equipment or products used at the clinic were identified. We saw evidence that safety alerts were kept and actioned as appropriate.
- All storage areas were clean and secure, and waste was appropriately discarded.
- We observed that sharps bins were clean and were emptied appropriately and sharps bin auditing took place to ensure staff compliance.
- In the recovery area we saw that the disposable curtains were dated to show when they were to be changed.
- The air ventilation in theatres was serviced on a yearly schedule to ensure compliance with the relevant Health Technical Memorandum (HTM). We saw that the next service date was due in November 2017.

Medicines

- There was a process in place to ensure care and treatment was provided in a safe way for all patients in regards to safe management of medicines.
- There was a policy in place for medicine management which included the procedure for prescribing, ordering, storage, administration, transport and disposal of medicines. The policy set out the roles, responsibilities and limitations for all staff to follow with regards to medicines.
- All clinical staff had completed their mandatory training in relation to medicine management and were aware of the policy governing their practices.
- Medicines were stored appropriately in a locked cupboard in the recovery area. The theatre manager was responsible for ordering medicines and was also responsible for the disposal of out of date medicines and to ensure there were adequate stocks of medicines for the planned surgical procedures. We saw that from the medicines we checked, all stock was rotated and all were in date and monthly audits were completed to check stock levels.
- We saw that the medicine used for sedation was counted prior to surgery and following surgery to record a full and accurate stock count.
- We saw that medicines that required cool storage were appropriately stored in fridges. We observed that the stocks had been rotated, they were all in date and fridge temperatures were recorded daily. All fridge temperature checks showed that the fridges remained within tolerance limits to ensure the medicines were stored at the correct temperature.
- There were no controlled drugs used by the service.
- There was a service level agreement with a local pharmacy for the supply of medicines to the clinic. Medicine prescribing was completed by the consultants in consultation with the patient.
- We saw evidence that the administration of eye drops for the anaesthesia of the eye prior to surgery was performed by staff that had been deemed competent. We saw evidence of competencies in their personnel files.
- A medicines audit was completed in September 2016 by the pharmacy service to ensure that the clinic was in-line with professional, legal and ethical requirements. The audit looked at the ordering, storage, administration, and disposal of medicines. The audit highlighted areas for improvement which included

multiple check of fridge temperatures to be recorded if the fridge falls out of range, some medication was not labelled, and medication with a short expiry date to be labelled 'use this pack first'.

- Prescriptions for patients to take home were written by the consultant. The prescription was electronically generated through the service electronic system. This system ensured that no prescription pads were used to prevent unauthorised use.
- In the August 2017 patient questionnaire all patients 100% reported either they had been told by a member of staff about medication side effects or felt they did not need an explanation

Records

- There was a system in place to ensure that records were accurate, secure and complete for every patient who attended the clinic for surgery.
- There was a records management policy to provide guidance for staff to follow to ensure that records were kept securely, and completed accurately.
- Paper records were kept of all treatment provided at the clinic, and then scanned into an electronic database to maintain a contemporaneous record of all pre-operative assessments, surgical treatment and post-operative appointments. Records contained all letters, costs for treatment, patient questionnaires, discussions, consent forms and all surgical notes including post-operative care.
- We observed that paper records were held securely to ensure patient confidentiality.
- The service completed records audits to ensure that records were being completed appropriately. We observed that audits looked at nine areas of recordings to ensure the records were complete. These included GP details, contact details, next of kin details and a record of each outpatient appointment. Results from the audit highlighted areas where records were not completed appropriately. We saw from the audits, areas for improvement were highlighted for discussion in the monthly business meeting.
- We saw that paper records audits and patient questionnaire audits had also been completed to ensure written records and patient questionnaires were completed fully. Results of the audit showed areas for improvement which included all records should be written in black ink and all entries made by medical staff need to be dated and signed with name printed. All records we reviewed had taken into account the audit findings.
- Pre-operative assessments were completed and recorded for each patient. Each patient upon admission was asked to complete a patient questionnaire to ensure the consultant had the most recent up to date information regarding the patient history and demographics. These were completed and returned to the clinic prior to a pre-operative appointment so that decisions by the surgeon could be made as to the suitability of surgery.
- We reviewed 12 patient records and found that they contained a full record of the patient care from pre-operative appointment, surgery and post-operative follow up.
- In the surgical records there was a log of all the items used in the surgical procedure including any implant that was used. This provided a record of what items had been used for traceability purposes.
- In theatre there was a surgical log book that contained the surgical procedure carried out with the names of the surgeon and team in the theatre. We saw that the log book contained the details and signatures of those involved in the surgical procedure.

Safeguarding

- There was a system in place to ensure that patients were protected from abuse and improper treatment.
- The service had a safeguarding adults and children's policy to provide support and guidance to staff in ensuring all patients were protected from abuse. We saw that the policy provided details of types of abuse and contact details of the local safeguarding team if a safeguarding referral was required. Staff we spoke with were able to explain who they would speak to if they needed to raise a safeguarding concern.
- The safeguarding policy did not reflect the latest guidance as it did not contain the details of guidance with regards to female genital mutilation. However, staff we spoke with were aware of the term as it was covered in their safeguarding training and would raise any concerns to their manager if this was reported to them. We raised this with the service managers and a new policy was developed for ratification by the clinical governance committee and dissemination to staff.

- The service withdrew services to children in May 2017 and the last child was seen in June 2017. Prior to this, in 2016, 17 children were seen, 14 of which were for medico-legal consultations or for optometric testing. The remaining three patients were follow up consultations with the surgeon. No treatment or nursing care was given to any of these patients.
- All staff we spoke with were aware of their responsibilities in regards to safeguarding patients who attended the clinic.
- The registered manager was the safeguarding lead for the organisation and had completed safeguarding level 3 in order to offer support and guidance to the staff team.
- Safeguarding training was provided to staff and bank staff on a yearly basis to support their knowledge. Information supplied by the provider showed that all healthcare staff had completed safeguarding adults training level 1 and 78% (one staff member had not completed) of clinical staff had completed level 2 training. We saw evidence of training certification in the staff training files.

Mandatory training

- There was a process in place to ensure that all staff employed at the service had received their mandatory training in order for them to carry out their role within the organisation.
- There was a mandatory training policy to provide staff with guidance on their mandatory requirements and who was accountable for ensuring compliance with legislation and policy requirements.
- Mandatory training was made available to all staff including bank staff to enable them to provide safe care and treatment to patients. Some of the training was completed through external training and e-learning. Staff we spoke with told us that they had access to training and also received training through suppliers with regards to equipment and medicines.
- Mandatory training included basic life support (BLS), fire training, moving and handling, adults safeguarding, and equality and diversity training.
- Records indicated that apart from safeguarding level 2 training (which was at 78%), all clinical staff had completed their mandatory training. All non-clinical staff (100%) had completed their mandatory training.
- All staff (100%) had completed basic life support (BLS) training and in theatre there was an Operating Department Practitioner (ODP) with immediate life support training (ILS) and all consultants, anaesthetists and the directors with Advanced Life Support (ALS) training to ensure patient safety was maintained should they need resuscitation.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- There were processes in place to ensure care and treatment was provided in a safe way to patients.
- The service had an admission, acceptance, transfer and discharge policy. The policy provided clear guidelines for all staff involved in the active management of these processes. The policy provided detailed instructions on the process for staff to follow to ensure patients were safely admitted, treated and discharged appropriately. We saw that staff followed the guidance set within the policy when admitting and discharging patients from the clinic which included asking patients to complete a patient questionnaire related to medical history and surgical history to ensure patients were suitable for surgery.
- The policy included the transfer of patients to an acute setting in the event of an emergency, and the acceptance criteria for surgery at the clinic. This ensured that surgery was only provided to those patients who were deemed appropriate for day case surgery and ensured that any patient whose health deteriorated was transferred to an appropriate care setting for treatment. Staff we spoke with were able to tell us the process to follow if a patient's health deteriorated whilst at the clinic including recognising the signs of sepsis.
- The hospital had a service level agreement with a nearby NHS hospital trust in case of any medical emergency. If there was an emergency there was always somebody on site who was trained in advanced life support skills and emergency equipment was readily available in theatre.
- A pre-operative assessment was completed for each patient prior to surgery. The assessment was a clinical risk assessment where the individual health of a patient was considered to ensure that they are fit to undergo the surgery. The pre-operative assessment included establishing if the patient required support from other professional services including psychological services.
- As part of the pre-operative assessment process, patients completed a comprehensive pre-admission medical questionnaire. These were reviewed at

pre-operative appointments to assess the suitability of patients for surgery and to carry out health assessments such as blood tests and swabs. It also gave an opportunity to ensure that patients were fully informed about the surgical procedure and the post-operative recovery period that included discharge and post-operative care.

- Risks to patients were assessed and monitored at pre-operative assessment, and then checked again prior to treatment by a registered nurse. The assessment included risks relating to mobility, medical history, last menstrual period, bleeding risk, pressure ulcer risk and VTE. During our inspection we looked at 12 sets of patient records, which showed all risk assessments had been completed correctly.
- Patient observations including blood pressure, pulse and temperature were taken pre- operatively, during surgery and post operatively so that staff could responded appropriately to changing risks to patients, including deteriorating health, sepsis, and wellbeing or medical emergencies.
- There was a safety huddle before each surgical session of all the staff involved in surgery. The safety huddle discussed the running order of the surgical list, any anaesthesia issues, the need for any special equipment and any patient allergies.
- Allergies were checked as part of the pre-operative assessment and were checked again once the patient was admitted, and rechecked again prior to anaesthetic. Patients with allergies wore a red wrist band as an extra safety alert to the surgical team.
- The five steps to safer surgery, World Health Organisation (WHO), checklist was completed by staff at appropriate stages of the surgical process. The WHO checklist is used by clinical teams to improve the safety of surgery. Checks included patient details, allergies, medicines prescribed to the patient, the area to be treated was marked according to the patient record.
- The service audited the WHO checklist to ensure that it was being completed appropriately to ensure all patients received safe care and treatment. We reviewed an audit completed in August 2016 and March 2017. The audits were completed over two week periods to establish that their adapted cataract WHO checklist was being properly completed for those patients undergoing cataract and occuplastic surgery. Results showed 100% of patients undergoing surgery had a WHO form. The audits highlighted areas for improvement, training needs, and changes to the WHO forms to ensure full compliance. We saw evidence that the WHO checklists were adapted to support the clinical staff and further educational material supplied to support staff.
- There was a resuscitation policy to provide guidance to staff in the event of a patient requiring resuscitation. The policy detailed the criteria and equipment required for resuscitation, including the training staff were required to attain.
- There was an automated external defibrillator available if necessary for use in clinical emergencies. Adrenaline was available in the theatre in case of an anaphylactic reaction, this was checked and was in date.
- Training scenarios were completed in the use of the automated external defibrillator (AED) and the evacuation chair in theatre to ensure the staff were confident and competent in their use. An automated external defibrillator (AED) is a lightweight, portable device that delivers an electric shock through the chest to the heart. The shock can potentially stop an irregular heart beat (arrhythmia) and allow a normal rhythm to resume following sudden cardiac arrest.
- Patients were moved to the discharge area once they were fit enough to leave the theatre area. Once in the discharge area patient observations were completed for at least one hour post surgery to ensure the patient was well enough to be discharged. Evidence in the records we reviewed showed that patients observations were completed in the discharge area and patients were deemed fit prior to being discharged.
- As the clinic was only open from Monday to Friday, complex surgical procedures were not performed on a Friday to ensure that patients who underwent surgery had access to the clinic on the day following a surgical procedure in case of any complication. We saw that if a surgical procedure was completed on a Friday the consultant performing the surgery contacted the patient on Saturday to complete a post operative follow up call.
- The clinic had a record log of all the general risk assessments completed with dates for review. We saw that the risk assessments included exposure to blood products, waste disposal and moving and handling.
- Patients were only discharged once they were medically fit and able. There was a criteria that their observations were in normal range, and they were able to mobilise within their own limits. If a patient was not fit to return home we were informed that a bed at a local private

hospital could be arranged. We saw from the records we reviewed that patient observations were completed throughout the patient journey from admission to discharge.

- Prior to discharge patients were given an emergency number to telephone should they have an emergency. The number provided direct access to the consultant. Patients we spoke with reported they had received the emergency telephone number which provided them with support if needed, and from the six patient records we examined, we saw that the telephone number had been given as part of the discharge checklist. Results from the August 2017 patient questionnaire showed 100% (N=32) of patients reported they knew who to contact if they were worried about their condition after leaving the clinic.
- Following a surgical procedure, all patients were given a follow up telephone call to establish any problems following their procedure. Patients we spoke with confirmed they received a call from the clinic. We reviewed the electronic records system for eight patients and saw that in the records, staff and consultants telephoned patients the following day including the weekend to establish if there were any problems following surgery.

Nursing and support staffing

- There were processes in place to ensure there were sufficient numbers of qualified, competent staff to meet the requirements of the daily function of the service.
- Daily team briefing took place to discuss the plans for the day within the theatre and to highlight any shortfalls in staffing.
- Staff we spoke to informed us that the theatre sessions would be cancelled if there was insufficient staff to meet the needs of the patients.
- Data provided by the service reported there were no cancelled procedures in the past 12 months due to non-clinical reasons.
- Theatres were staffed according to the number of patients and type of anaesthesia. The theatre was staffed with a surgeon, anaesthetist, an assistant for each and a runner. Theatres were staffed as a minimum with one assistant for each consultant. From our observations there were enough staff to meet the needs of the patients.
- In theatres there was a theatre manager to provide the necessary daily management and oversight for the department.
- The service used a regular experienced group of bank staff to provide the necessary skill mix of staff in theatres. In the period from April 2016 to March 2017 the range of bank staff used was 41% to 61% for nursing staff and for operating department practitioners and healthcare assistants was 5% to 23%. The service used an operating model based upon three substantive staff and six regular bank staff to fulfil the requirements of the service. Managers of the service told us that this provided the flexibility they required to manage the service effectively.
- There were no vacancies in the theatre department as at 1 April 2017.
- Sickness rates for theatre nurses, ODPs and health care assistants were 0% throughout the reporting period April 2016 to March 2017, except in February 2017 when the rate of sickness for theatre and health care assistants was 4%.
- There was no staff turnover for theatre nurses, operating department practitioners or health care assistants in the previous or current reporting period April 2016 to March 2017.

Medical staffing

- There were eighteen doctors who had practising privileges at the clinic. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. The majority of these also worked at other NHS trusts in the area. They included consultants with specialities such as ophthalmology and cosmetic surgery.
- All treatment was consultant led at the clinic. Following surgery the continued care of the patient remained the responsibility of the surgical consultant. This ensured that the consultant remained involved with the patient care pathway throughout their journey from pre-admission to discharge.
- Following a surgical procedure the consultant remained on-call out of hours to ensure that should a patient experience any complication they could telephone for support.
- All cosmetic surgeons (four) who carried out surgery at the clinic were on the General Medical Council (GMC) specialist register for cosmetic surgery.

Good

Surgery

Emergency awareness and training

- The service had a business continuity plan that outlined the risks that could disrupt business activity. The risks included IT failure, power failure, fire and mechanical failure.
- There was a backup generator in theatre so if the power supply failed then the generator would provide power to complete the current surgical procedure.
- Staff we spoke with were aware of the emergency procedures and regular fire safety testing was completed.
- We saw that an external contractor provided a report following a fire safety assessment to show fire safety compliance with any areas for remedial action.
- We were informed that fire evacuation procedures included the use of the emergency evacuation chair in theatre to ensure staff were competent and confident in its use.

Are surgery services effective?

Good

Evidence-based care and treatment

- There were processes in place to assess, evaluate and improve practice in the theatre to ensure that patients received care and treatment to meet their needs and reflect good practice.
- Care and treatment was delivered to patients in line with evidence-based practice and national guidance such as those from the National Institute for Health and Care Excellence (NICE). For example, patients were assessed for venous thromboembolism (VTE). This is the blocking of a blood vessel by a blood clot dislodged from its site of origin. This was in-line with national guidelines from the National Institute for Health and Care Excellence (NICE) QS3 Statement 1.
- We saw the service had an up to date audit schedule to ensure all staff and procedures complied with the clinic policy and procedures to maintain patient safety. The audit schedule included hand hygiene, aseptic technique, patient records, consent and infection control.
- The service had developed local safety standards for invasive procedures which included the use of the World health Organisation checklist (WHO) for all surgery performed. The procedures set out what must be performed to ensure patient safety before, during and after surgery. We saw that the procedures provided all staff with the safety checks to follow to ensure patient safety.
- The service had developed pathways to ensure that patients received safe care and treatment. We saw that a pathway for patients undergoing eye surgery included checklists of assessments completed. For example, medication, observations, the type of eye drop used, sight marking, anaesthesia details and pain score. We saw that the implants used were added to the pathway to aid traceability and included a discharge checklist.
- External assessors were used to ensure compliance with legislation. We saw evidence that external contractors were used to assess the service in relation to health and safety, fire, infection control and prevention. We saw evidence that reports had been actioned and were discussed in meetings with action plans developed to ensure compliance.

Pain relief

- Pain relief was discussed with patients as part of their pre-operative assessment and following surgery. We saw from records that pain relief was documented in the patient record and patients we spoke with confirmed that pain had been discussed with them throughout their treatment.
- We saw from the records we reviewed that pain was discussed as part of the pre-operative appointment, on the day of admission before and after surgery and a pain score noted to ensure adequate pain relief was given.
- We saw that the service completed pain relief audits to ensure that all patients receiving treatment at the clinic did not experience pain or too much discomfort. Pain relief audits were undertaken yearly. We saw from the audit completed in 2016 that 100% of patients (21 in total) who had undergone eye lid surgery found the pain medication advised was adequate to ensure they slept the night after surgery and did not complain of pain when called post operatively.
- We reviewed the records of eight patient who had been discharged and saw that staff including consultants had telephoned patients the day after their surgery and pain scores had been documented.

- Patients undergoing lower lid or upper lid eye surgery were given intravenous paracetamol in theatre to ensure the patient remained comfortable and pain free during and after their surgical procedure.
- The service did not routinely prescribe strong pain relief, and instead were more selective in prescribing strong pain killers based upon the nature of the surgical procedure. We saw that the type of pain relief was discussed at the pre-operative assessment.
- Patients were advised about suitable medication for post operative pain and discomfort. Paracetamol was not routinely prescribed to the patients but were offered the prescription if they do not have some at home.

Nutrition and hydration

- Those patients who were required to fast prior to having surgery had this explained to them prior to undergoing a surgical procedure. We saw this was documented in the patient operating pathway, which included the time they last ate and drank. Fasting arrangements were based upon the type of anaesthesia used for the surgical procedure. This followed Royal College of Anaesthetists guidance.
- Following surgery patients were moved from the recovery area to the discharge area to fully recover from their surgery. Whilst in the discharge are they were offered light refreshments or were able to bring their own food if required.
- In 2017, the service changed the format of the information regarding fasting instructions for surgery. This was due to three incidents where patients had not followed guidance provided to them regarding starving before surgery resulting in a cancelled procedure. The service changed the format of the instructions to large bold print and red lettering to highlight the importance of the instructions. A pre-operative call was also introduced to verbally emphasise the starving before surgery instructions. The service reported that following this change of procedure they have had no instances of patients arriving for surgery who had not followed the starving before surgery advice.

Patient outcomes

- Information about the outcomes of patients' care and treatment was collected and monitored by the service. Staff we spoke with were aware of the collection of data for auditing which included patient satisfaction through patient satisfaction questionnaires and the friends and family test (FFT). We observed that the results from the patient satisfaction questionnaires were posted on the wall in the staff room to ensure staff remained up to date with customer satisfaction.
- The service had in the last three months started submitting patient reported outcome measures (PROMS) for those patients who had undergone cataract surgery. PROMS are patient reported outcome measures, which describe the level of patient satisfaction with certain operations. We were informed by the service that the results of the outcome data were not yet available.
- Data was submitted to the Private Healthcare Information Network (PHIN) for cataract surgery. PHIN is the independent, government-mandated source of information about private healthcare, working to empower patients to make better-informed choices of care providers. We saw that patient registration forms included a consent form to collect data for PHIN.
- The Royal College of Surgeons (RCS) recommends that providers routinely collect and report on Q-PROMs for all patients receiving cosmetic procedures. From June 2017 the service started participating in QPROMS for cosmetic surgery to ascertain the level of satisfaction with the cosmetic procedures offered. We were informed by the service that the results of the outcome data were not yet available.
- A consultant who led on lower lid trans conjunctival blepharoplasty (the concept of operating on the lower eyelid from the inside of the lid) kept outcome data on all their patients since 2008, to look at performance and patient satisfaction. We saw the data was anonymised for patient confidentiality and included any complications, patient satisfaction, and any supplementary treatment required.
- There was an ongoing audit of patients undergoing ptosis surgery (drooping or falling of the upper eyelid) and lower lid blepharoplasty (eyelid). The clinic re-do rate for ptosis surgery was 12.5% compared to the national average of 20%. The clinic re-do rate for lower lid blepharoplasty was less than 5% but there are no nationally published figures to compare this to.
- There were no unplanned readmissions to theatre within the reporting period from April 2016 to March 2017.

Competent staff

- There was a process in place to ensure that all staff employed at the service had the right qualifications, competence, skills and experience necessary in order for them to carry out their role within the organisation.
- We saw that staff files contained competencies attained in order for them to be trained and confident in carrying out their duties. Competencies included eye drop administration, medication, positioning of patients and aseptic non touch technique.
- We saw in staff files that if a member of staff attended a conference then fed back to the team on the topic discussed to aid learning and development.
- Staff we spoke with reported they received regular feedback on their performance.
- The service had a clinical supervision policy to ensure staff received appropriate levels of support. Supervision is a practice focused, professional relationship involving a clinician reflecting on practice guided by a supervisor. We saw from the staff files that staff signed an individual supervision contract and were expected to complete six hours per year of clinical supervision. This included shadowing others practice and time for reflection.
- Alongside clinical supervision, staff received an annual appraisal. The appraisal rate for all staff including bank staff in 2016 and 2017 was100%. The main purpose of appraisal is to give the appraisee the opportunity to reflect on their work and learning needs in order to improve their performance. This can be achieved through discussing their development and feedback on their job performance in a way that is constructive and motivational. It should result in an effective personal development plan. We reviewed appraisals for three staff and found that all had a personal development plan. Staff we spoke with reported they found the appraisal process to be supportive in their development. Each appraisal had an agreed competency level with a statement of outcome so they were able to demonstrate what was required to meet the competency level. This included an assessment of competence on three occasions with a random competency audit yearly to demonstrate their knowledge and skill.
- We saw in one competency file that the staff member demonstrated positioning of a patient and received feedback from two medical practitioners on their competency.
- All staff we spoke with told us that there were opportunities for training and were given time to enhance their skills.
- All registered nurses (100%) had validation of professional registration in the reporting period April 2016 to March 2017. This meant the clinic conducted annual checks to make sure all the nurses are registered with the Nursing and Midwifery Council (NMC) and is considered good practice. Managers had oversight of who required revalidation in order to ensure all nurses were registered with the NMC.
- There was a practising privileges policy for consultants who wished to work at the clinic, and the ongoing requirements for those who were granted practising privileges. The policy set out a clear process for the granting of practising privileges for new consultants. This required consultants to send in a CV, a formal application, and interview.
- Applications for practising privileges were approved by the directors once all satisfactory paperwork has been received which included evidence from the GMC, scope of practice, appraisal, revalidation and indemnity insurance. (Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital).
- A director, who was also the clinical lead, had oversight of the surgeons working at the clinic, supported by the administration manager and the registered manager of the service. The consultant files contained copies of their NHS appraisals showing their qualifications, continuing professional development, disclosure and barring service check (DBS), indemnity insurance, revalidation and data protection certificates.
- The service provided input into the consultant annual appraisal which included the surgeries performed, patient satisfaction and complaints.
- We saw that the consultant practicing privileges was audited yearly to ensure they had received all the necessary documents from the consultants in order for them to practice at the clinic. The audit completed in 2017, showed that all (100%) of consultants employed under practicing privileges had submitted the necessary documents.

Multidisciplinary working

- The staff at the clinic, including the consultants, worked as a team. There was a good team ethos that focused on patient safety and patient experience.

- All staff we spoke with reported that they worked well together and had good relationships with each other and consultants.
- We observed positive working relationships between managers and the staff groups. We observed managers across the department to have close professional relationships with the staffing groups and provided them with advice and guidance as required.
- Consultants at the clinic trained other doctors in the field of oculoplastic surgery and were invited to speak both nationally and internationally at conferences. We were informed other providers of cosmetic eyelid surgery in the UK refer their surgical complications to them in acknowledgement of their expertise.

Access to information

- Staff told us they had access to policies and procedures and felt they were kept informed by the management team. Policies were held on a central database so staff could access them as required.
- Patient records were scanned into an electronic system so they were easily accessible from their workstation computers.
- Computers were available across the clinic. All staff had secure, personal log in details and had access to e-mail and clinic systems. We observed that no computer terminals were left unattended displaying confidential information.
- An information governance audit was completed in February 2016, to ensure staff were compliant with information governance procedures. We saw the audit took into account the positioning of the computer monitors, password protection and ensured the electronic system had up to date virus software.
- Following the consent from patients, care summaries were sent to GPs on discharge to ensure continuity of care within the community. We saw evidence of copies of the discharge summaries in patient records we examined.
- We observed that following surgery, the consultants typed up their surgical notes to ensure they were legible.
- Patients were provided with information pre and post operatively to fully understand the surgical procedure and post-operative instructions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had processes in place to ensure that care and treatment delivered was only provided with the consent of the relevant person.
- There was a consent to examination and treatment policy to ensure best practice in the process of obtaining consent. The policy set out that patients have a fundamental legal and ethical right to determine what happens to their own bodies and the essential need to obtain valid consent to treatment.
- Consent to treatment was a two stage process. Consent to surgery was gained from patients during their outpatient appointment and again prior to having the surgery. Patients were required to sign the consent form following their consultation and had fully understood the procedure they were undertaking. The second stage of the consent process required the patient to sign the consent form on the day of surgery following a period of at least one week prior to eye surgery and two weeks prior to cosmetic surgery. This is known as the 'cool off' period. We reviewed a further eight patient records and found that all patients had at least a two week cool off period from consenting to treatment and actual treatment taking place.
- There was a mental capacity act and deprivation of liberty safeguards (DOLS) policy in place for all staff to follow. The policy outlined that although they clinic would rarely see and treat patients who lacked the capacity to consent to treatment they recognised the importance that staff should be aware of the act and any implications which relate to their patients. From our conversations with the staff they had an understanding of the mental capacity act and the consent process.
- Consent training was provided to both clinical and non-clinical staff as part of their mandatory training. Training statistics provided by the service showed that all staff (100%) had completed this training.
- The service audited consent forms yearly as part of their audit schedule to ensure that consent was obtained at both the pre-operative assessment and on the day of the surgical procedure. All records we reviewed contained a signed two stage consent form.
- The consent audit completed in February 2017, looked at 44 patient's records and found that all had a detailed consent record and all patients had been provided with the information regarding their condition and surgical procedure.

Good

Surgery

- We saw that in the patient pre-assessment questionnaire patients signed to give consent to have photographs taken for their medical records.

Are surgery services caring?

Good

Compassionate care

- The service had a privacy and dignity policy for the staff to follow to ensure that patients were treated with dignity and respect. The policy set out the attitudes and behaviours that staff must adhere to, and there was an accountable person to ensure the dignity and privacy of patients.
- In the August 2017 patient survey, 100% of patients (total of 32) reported that they were given enough privacy when discussing their condition or treatment.
- We observed patient interactions between staff and patients and saw that patients were made welcome at the clinic and all staff were kind and courteous.
- We saw that staff treated patients with dignity and respect at all times and all patients we spoke with confirmed this.
- The service participated in the Family & Friends Test (FFT). Of those who responded, 100% of patients would recommend the service to their friends and family. The average response rate for January to March 2017 was 59%.
- We spoke with five patients who all told us that that they were treated with dignity and respect by all members of staff. Patients told us they found the staff polite, friendly and approachable. Comments included. “Staff are fabulous and lovely”.
- We observed staff greeting patients on their arrival and introducing themselves. Staff were polite friendly and helpful in their approach.
- We saw that staff respected patient confidentiality and ensured discussions took place in treatment rooms for privacy. All patients we asked reported that their dignity and privacy was maintained throughout their stay. At reception patients could choose not to discuss any details at the reception desk and there was a side room available for sensitive discussions.
- We observed many positive interactions between staff and patients during our inspection. We saw that staff were very professional, welcoming, approachable and friendly. Patients we spoke with were very positive about the way staff treated them. Patients told us staff were ‘excellent’, ‘fantastic’ and ‘wonderful’.
- We saw that staff completed reflective practices to share with other staff to aid learning. We saw in one file that a member of staff had completed a reflective practice to share with other staff members the importance of being mindful of patient’s feelings and emotions.
- The service routinely asked for feedback from patients using the clinic’s patient feedback questionnaire. We reviewed 43 clinic feedback comment cards received from July to September 2017. All feedback was highly complementary regarding the staff and the level of service received at the clinic.
- We received 11 ‘tell us what you think cards’ from patients receiving treatment at the service. All comments were extremely positive regarding the care they had received at the clinic.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so that they understood their care, treatment and condition. Patients confirmed that staff explained their care and treatment, and kept them up to date with any required information
- Patients told us that they were involved in planning and making decisions about their care and treatment and they had everything they needed explained to them before surgery.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment. This was highlighted in the preoperative assessment so reasonable adjustments could be made. We read many letters of thanks from patients who had attended the clinic for surgery. We saw in letters patients reported that although they were apprehensive and anxious the staff at the clinic placed them at ease and were very understanding.
- Patients we spoke with told us that ‘staff took their time to help me understand’, ‘the staff provided me with all the information I needed’ and ‘I had plenty of time to ask questions’.
- Following a patient waiting time audit in 2016, the clinic had extended the time for appointments to allow more time for each consultation. This was due to a number of

clinics over running their time. This change in practice allowed for the consultants to spend more time with patients to help them understand and be more involved in their care and treatment.

Emotional support

- Patients we spoke with told us 'staff put me at ease'; 'they took their time and did not rush me'.
- Contact details were given to patients when they were discharged. This enabled them to contact their consultant should they have any worries or fears.
- The psychological wellbeing of patients was assessed as part of the pre-operative assessment for cosmetic surgery. Following discussions with the consultant any patient deemed to require further psychological assessment could be referred to psychological services prior to any surgical procedure taking place.
- Staff supported patients during surgery if necessary by holding their hand.
- The emotional and social needs of a patient were a part of their care pathway for discussion through preoperative assessment to the day of surgery. Any patient concerns or worries were included in how the patients care and treatment was managed. This included chaperones to support during assessments.
- In the August 2017 patient survey, 100% (total of 32) of patients reported they were given an opportunity to discuss any concerns or queries with a member of staff.

Are surgery services responsive?

Good

Service planning and delivery to meet the needs of local people

- The services supported the needs of the local population by providing services to insured, NHS patients and self-paying patients alike.
- Services provided reflected the needs of the population they served, and they ensured flexibility, choice and continuity of care. A variety of surgical procedures were available within the service, including cosmetic surgery, and eye surgery.
- The service supported the reduction of NHS waiting lists in eye surgery, by providing surgical procedures at the clinic. The procedures carried out were determined in conjunction with the local NHS trusts in order to reduce their waiting lists for patients receiving treatment.
- The service offered patients access to consultants of their choice, who had practising privileges at the clinic.
- Integrated care pathways were used when planning and delivering treatment. This ensured that patients' needs from preoperative assessment through to discharge were taken into account.

Access and flow

- There were 361 day-case attendances to theatre between April 2016 and March 2017.
- Between April 2016 and March 2017, approximately 14% of all patients were NHS funded, and with the remaining 86% were private insured and self-paying patients.
- Patients accessed care and treatment at a time to suit them. Patients we spoke with told us they were given a choice of dates for their procedure, and reported they did not wait long for their surgical procedure to take place. Staff we spoke with confirmed that patients were seen quickly once a referral was received. The service informally monitored their referral to treatment times to ensure all patients were seen in a timely way. We were informed that patients did not need to wait long and were always seen within two weeks. Any delays in being seen were due to patients wishing to see a particular consultant who may be on leave and did not want to see a different consultant.
- The number of appointments per day varied. At the time of inspection there were 11 appointments booked for either surgery or a consultation. Appointments were based upon the availability of consultants and from our observations patients were seen quickly, and the environment was calm and relaxed.
- We saw from the appointment booking system that patients were given an allotted time with their consultant which was based upon the type and complexity of the surgery and the needs of the patient. We were informed that all appointment times were flexible and could be changed to meet the needs of the patient.

- Patients were given staggered times to arrive for surgery. This meant that patients were not required to wait long before their surgery was performed as the timings of the surgery were planned to take into account the complex nature of the procedure undertaken.
- Patients informed us that they did not wait long before they received surgery on their day of admission and from our observations patients were quickly seen and treated.
- There were no cancelled procedures for non-clinical reasons in the reporting period from April 2016 to March 2017.
- Any delays to appointment times were managed by the reception staff. We were informed that any delays were communicated to patients prior to their arrival to ensure they did not need to wait long before being seen.
- Patients were moved to the discharge area once they were fit enough to leave the theatre area. This area was staffed so patient observations could be taken. The use of this area ensured that once a patient was discharged from recovery the next patient could be taken through to the theatre to aid theatre throughput. Patients remained in the discharge area until they were well enough to be discharged.

Meeting people's individual needs

- Services were planned and delivered to take account of the needs of different patients. Individual needs were considered at preoperative assessments to ensure their needs could be met. The service had a criteria of those patients who would not be suitable for surgery at the clinic based upon their existing co-morbidities.
- The service offered day case surgery only. However, if a hospital bed was required they were able to arrange this for patients at a neighbouring private clinic.
- More complex surgery was performed during the morning surgical list. This meant that once the patient was discharged if there were any complications or patient concerns they could be readmitted to the clinic the same day.
- We were informed that patients with diabetes received their surgical procedure at the best time to suit their needs. We saw from day of admission for surgery documentation that blood sugar monitoring was completed prior to surgery taking place to ensure that patient was at their optimum for surgery. Staff we spoke with reported patients with diabetes usually had surgery during the morning list so as not to interfere with their usual eating routine.
- The service had developed a text reminding service to remind patients of their upcoming appointment.
- All areas of the clinic were wheelchair accessible, and there was a bathroom which had been adapted for patients with mobility difficulties and was large enough to enable carers to support if needed.
- There was an interpreter service available for patients for whom English was not their first language. Staff were aware of the service and how to access it. This included access to sign language for those patients who hearing difficulties.
- There was also a hearing loop system in reception for those patients with a hearing impairment.
- Information packs were tailored to each specific treatment and as these packs were made to order they could be tailored for each patient. For example, the font size and colour of the text could be changed and then printed to aid patients with eye sight problems.
- The clinic provided a range of information leaflets about different conditions and treatments. The information was in English; however we were informed that other language formats could be available if required.
- Staff we spoke with reported that for those patients with sight impairments, the information leaflets could be produced in larger fonts to aid reading.
- The service carried out a Disability Discrimination Act (DDA) audit yearly to ensure that all patients could access the clinic. The audit looked at the physical access, and facilities to ensure all areas could be accessed. We saw the audit including the height of the tables and space around the unit for wheelchairs.
- Patients were provided with refreshments including something to eat following surgery. Prior to their admission patients were asked about any food intolerances so that special provisions could be purchased. For example, gluten free and soya products.
- There was free availability of tea and coffee and a water cooler for preoperative patients and waiting family members in the reception.
- There were dedicated spaces for patients attending the clinic and a dedicated space at the entrance for an ambulance should it be required.

Good

Surgery

- The service had a chaperone policy which provided guidance on the use of chaperones for intimate examinations and consultations at the clinic. We saw posters offering this service in the main reception and in the corridor to the consulting rooms.
- The service had implemented a dementia strategy. The strategy included raising awareness and understanding of dementia by staff training, the introduction of a dementia champion, and had developed a resource folder with local contacts and information leaflets for patients and relatives.
- Surgical patients were cared for by a named nurse who oversaw their care from admission through to discharge. This ensured continuity of care for the patient.
- Following discharge patients were advised to contact the clinic should they have any worries or concerns with their procedure. We saw this information was given to patients as part of the discharge arrangements.

Learning from complaints and concerns

- There were processes in place to ensure that any complaint received was investigated and necessary proportionate action taken.
- In the reporting period from April 2016 to March 2017 the service had received five complaints. Four of these complaints were verbal complaints and one was a written complaint by a patient who had already made a verbal complaint.
- The registered manager was responsible for overseeing the management of complaints. Directors provided a second stage review of a complaint should a complainant remain dissatisfied with the first response.
- Complaints were also logged using a complaints summary to detail the nature of the complaint, the outcome, and any changes in practice. We saw that complaints were a set agenda item in the business meeting. Staff we spoke with reported that following a complaint they were informed of its nature and outcome to aid learning.
- The service had a complaints policy that set out the complaints procedure and timescales in which complaints were to be resolved. Complaint acknowledgement was to be made within two working days. The complaint should then be investigated and the results provided to the complainant as soon as possible, but within 20 working days unless there was a clear reason for extending the timescale. We saw that the complaints policy was being followed.
- The service was not a member of the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). The Independent Sector Complaints Adjudication Service (ISCAS) is the recognised complaints management framework in the independent healthcare sector. ISCAS is a voluntary subscription scheme that represents the vast majority of all independent healthcare providers across the UK. As the service was not a member of ISCAS, self-funding patients who remained dissatisfied with the outcome of their complaint needed to contact the General Medical Council (GMC) about their surgeon. Managers of the service reported that due to the low numbers of complaints they did not feel it necessary to become a member of this service.
- Patients receiving treatment through the NHS were able to complain to the Parliamentary and Health Service Ombudsman (PHSO) if they remained dissatisfied with the decision made by the clinic. Patients could also complain about an individual surgeon's practice to the GMC. The ombudsman makes final decisions on complaints that have not been resolved. We were informed that no NHS patients had made a complaint about their treatment through this service.
- Leaflets on how to make a complaint were available in reception and the complaints process was included in the 'Guide to Face & Eye' booklet which is given to all surgical patients following their preoperative assessment.

Are surgery services well-led?

Good

Leadership / culture of service related to this core service

- The leadership of the service was provided by three directors, the registered manager, the administration manager and the theatre manager. We saw there was an organistaional structure that defined who was responsible for each area including the staffing.
- The senior managers had the skills, knowledge, experience and integrity to lead effectively. We saw from meeting minutes they regularly attended meetings to discuss the performance of the service.

- Staff were aware of the management structure and who they were accountable to. The service had a service lead; and there was an established management team who managed specific areas of the service. This included the registered manager, administration manager and theatre manager.
- All staff we spoke with were positive about their relationships with their immediate managers. Staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to.
- We saw during the inspection that there was a board to ward assurance system in place. We saw that information relating to the performance of the service was shared with the staff and actions were taken to ensure performance was improved. For example, following an incident or external inspection action plans were developed for improvement.
- We saw that leadership of the service was extremely good; there was excellent staff morale and all staff told us they felt supported to be able to deliver safe care and treatment to patients. Staff told us the management team had an 'open door' approach, and were available to provide advice and guidance as needed.
- All senior clinical staff had worked in ophthalmic for a minimum of 10 years which provided them with a wealth of experience to meet the needs of ophthalmic patients.

Vision and strategy for this core service

- There was a vision and strategy plan for 2016- 2019 to shape the direction of the organisation. The plan set out the vision and strategy, the strategic goals they were going to achieve. All staff we spoke with were aware of the vision and strategy and the direction of the organisation and had signed up to the objectives set by the organisation.
- The service had an up to date business plan which provided the goals and objectives for the service. We saw that the plan included a strengths and weaknesses analysis. Senior staff we spoke with were aware of the current strengths and weaknesses of the business.
- There was a clinical governance structure, with an organisational flow chart to provide a reporting structure for all staff to follow. The structure included directors, the registered manager, theatre manager and administration manager.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- There was a process in place to assess, monitor and mitigate risks relating to the health and safety and welfare of the patients and staff.
- We saw there was a risk management policy to provide guidance to all staff and managers to follow. The policy explained the underlying approach to risk management, documented the roles and responsibilities of the directors, managers and staff. It also outlined key aspects of the risk management process, and main reporting procedures. We saw that risk management was undertaken as risk assessments were completed for the environment and the equipment, and there were policies and procedures to govern the operation of the organisation which had been reviewed and were in date. The service commissioned external services to ensure compliance with health and safety and infection prevention control and actioned the findings from the reports. We saw that action plans were completed and results discussed in clinical governance meetings.
- Staff were required to read and sign policies, procedures and risk assessments to ensure they understood their individual requirements. We saw that copies of the policies were also stored on an electronic database for staff to refer to as required. Staff signed a signatory sheet at the front of the policy or risk files. However, this did not provide assurance that staff had read and signed all, or the most up to date copies of any policies or assessments as they were updated.
- Senior leaders met on a monthly basis to discuss the performance of the clinic. We saw from the clinical governance meetings minutes that the discussions included governance, equipment, incidents, complaints and compliments, health and safety, audit results and training. The meeting provided senior leaders with assurance of patient safety and operational performance of the clinic.
- Separate to the clinical governance meetings there were business meetings to discuss the operation of the business that were non-clinical. We saw that all senior leaders of the service attended these meetings.
- The Medical Advisory Committee (MAC) meetings were encompassed into the clinical governance meeting to discuss consultant practicing privileges and operational results. We saw minutes of meetings to confirm this.

However, although the meetings included senior staff and the three director/consultants from the clinic, they did not include any of the wider consultant team to share knowledge, risk and performance. The role of the MAC is to be the formal organisational structure that ensures clinical services, procedures or interventions are provided by competent medical practitioners, their clinical responsibilities; matters concerning clinical practice at the facility; matters concerning the care and safety of patients at the facility; and any other matter relating to the safety and quality of services at the facility.

- Managers were conversant in understanding that all staff working under practicing privileges were required to provide evidence that they had the appropriate level of indemnity insurance, qualifications, appraisal and revalidation. We saw that this was audited and there was a process in place to ensure all consultant personnel files contained the required documentation. All files we reviewed for consultants were up to date and contained the necessary documentation.
- The service had a clinical governance policy which set out eight key elements in supporting good clinical governance. These included, training, audit, risk management and information management. Clinical governance refers to the structures, processes and systems in place in an organisation to manage the quality of service provision. Senior leaders we spoke with were aware of their role in ensuring quality service provision, and we saw evidence that training, audit, risk assessment and information management were taking place at the clinic.
- We observed that the service had an up to date health and safety policy that all staff read and signed. The policy set out what was expected from the organisation and from its employees to ensure safety of patients and themselves.
- The service commissioned a yearly health and safety inspection to ensure compliance across the clinic. We saw that from the health and safety report actions had been taken to ensure conformity with health and safety legislation.
- Managers at all levels understood their responsibilities to ensure and protect the safety of patients from harm. Local safety standards for invasive procedures (LocSSIPs) were in place to ensure staff were competent; records kept of procedures carried out, and patient records reflected the procedures completed. We saw that effective team working had been developed and staff were aware of their roles and responsibilities. We also saw that checklists were performed to protect against wrong site surgery and auditing took place to check performance and compliance.
- Working arrangements with partners and third party providers were well managed. Each Service Level Agreement (SLA) had a process of review which was monitored. We saw that SLA's were held for pharmacy, pathology, and emergency transfer of adult critically ill patients to NHS.
- The service completed an annual quality assurance report for dissemination with all staff working at the organisation. The report for 2016 to 2017 highlighted the three key areas of their quality strategy. These included patient experience, patient safety and clinical effectiveness. Although the report discussed findings over the year regarding patient safety, we saw that in the complaints section there was no discussion or learning shared from complaints received throughout the year.
- We saw the service used an electronic compliance tool that followed CQC methodology to support with ensuring regulatory compliance. The tool enabled the service to identify their areas of strengths and weaknesses.

Public and staff engagement (local and service level if this is the main core service)

- The service invited all patients to complete a patient satisfaction survey to measure their performance. We saw the results were displayed on their website and within the clinic.
- The service website provided advice regarding types of procedures the clinic was able to perform and there were many scanned letters of thanks as testimonials from previous patients.
- Response rates in the friends and family test were positive with a 59% response rate from January to March 2017. This showed that the service engaged with the patients and provided a process in order to establish patient views. We saw that the response rate did not drop below 50% in the period from October 2016 to March 2017, and from all those who responded 100% of patients would recommend the service to friends and family.
- The clinic had been recently introduced their own patient feedback forms which were positioned around the clinic for patients to complete. Feedback and

comments from these sources helped identify what the service did well and areas for improvement. From the 43 clinic feedback questionnaires we reviewed all the comments were very positive and did not identify any areas for immediate action for improvement.

- A staff survey had been completed in 2016. The survey was used to gather staff views in order to further improve service performance and enhance the service for patients. We saw that from the survey the service was introducing more formal meetings, along with some team building activities to enhance staff engagement.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The service introduced a GP liaison role within the clinic to promote their services. This had led to a programme of education with local GP's to enhance knowledge in identified specialities through a series of learning events throughout 2016 and 2017. We saw the feedback from an event was very positive from the attending GP's.
- Further training opportunities have been made available for non-clinical staff to support development of the workforce. One member of staff we spoke with told us they were starting a new training programme to support them in a new role within in the theatre department.
- Two of the surgeons at the clinic were founder members of the British Oculoplastic Surgery Society (BOPSS). The purpose of BOPSS is to advance the education, research and quality of care in plastic, reconstructive and aesthetic surgery of the eyelids, the surrounding facial areas, orbits and lacrimal system. We were informed they regularly train other doctors in the field of oculoplastic surgery and are invited to speak both nationally and internationally, and other providers of cosmetic eyelid surgery in the UK refer their surgical complications to them in acknowledgement of their expertise. Patients we spoke with informed us that they were having surgery or corrective surgery at the clinic based upon findings of the consultant clinical expertise and having read articles written by the consultants on the internet. We also saw that the clinic saw and treated patients from all over the UK.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

Incidents

- The service had an incident management policy, which outlined the arrangements for reporting, managing and learning from incidents arising from any activities undertaken by employed staff.
- All staff spoken with in the Outpatient Department (OPD) told us they were supported to raise any potential risks or concerns. They were confident that they were made aware of how to raise incidents. Staff also told us they were informed of learning as a result of incident investigations that assisted in improving the services performance.
- Managers and clinicians reviewed and investigated incidents appropriately. Records we reviewed confirmed that staff raised concerns immediately and the registered manager investigated the issue and kept records detailing the outcomes. Clinicians investigated clinical incidents and we saw records which confirmed that changes had been made to practice following an incident, if necessary.

Cleanliness, infection control and hygiene

- The service had reported no incidence of Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C Difficile) or Methicillin -sensitive Staphylococcus Aureus (MSSA) in the reporting period between April 2016 and March 2017. MRSA, MSSA and C.difficile are all infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated. C.Difficile is a bacteria affecting the digestive system; it often affects people who have been given antibiotics.
- The service commissioned an independent infection control audit of clinic rooms and the environment. The audit aimed to identify any areas where the department were not meeting national standards and guidance. Results from the audit showed the outpatient area had met national standards for cleanliness.
- The environment was visibly clean. The service had clear cleaning schedules and procedures including different coloured mops for different areas to reduce the spread of germs and bacteria. Staff cleaned consulting rooms, toilets and waiting areas daily. Domestic staff undertook weekly and daily cleaning checks. We saw staff completed records of checks.
- We observed all staff were bare below the elbow, in keeping with clinic policy to help prevent the spread of infection.
- Hand gel was available at the entrance to clinics and in the waiting areas. We observed staff using the gel to clean their hands in accordance with clinic policy and good practice guidelines, for example National Institute for Health and Care Excellence (NICE) QS61 statement three: staff cleaning hands before and after each episode of care.

Environment and equipment

- The environment was appropriate for delivering safe care and treatment. The environment was well lit and uncluttered. Consulting rooms were organised and space was available and appropriate for private

conversations. Equipment was stored in appropriately sized rooms allowing staff to move and freely examine patients. The service had the latest up to date equipment to support delivering safe patient care.
- Staff had access to resuscitation equipment located in the patient waiting area. For further information on resuscitation equipment, please see the surgery report.

Medicines

- For our detailed findings on medicines please see the Safe section in the Surgery report.

Records

- All patient records we reviewed contained patient risk assessments, records of appointments and preoperative assessments. All the sets were in chronological order meaning the most recent clinic appointment was at the front of the notes.
- The service conducted audits of the quality of their records. Audits provided by the provider demonstrated records met clinic standards. During our inspection we sampled 12 patient records. All of the records sampled were complete and contained all necessary information.
- The outpatient service had procedures to dispose of confidential waste. Staff used cross shredders, which ensured confidential information could not be visible, or seen by other patients or members of the public.
- For detailed findings on records, please see the Safe section in the surgery report.

Safeguarding

- Records we reviewed confirmed that the service had clear guidance and processes on safeguarding vulnerable adults and children. For further detail please see the Safe section in the surgery report.

Mandatory training

- Staff received mandatory training annually. Records we reviewed confirmed that staff had attended training days which included fire safety, customer service, basic life support (BLS) and safeguarding. The registered manager had responsibility for ensuring all staff attended the training. All staff we spoke with confirmed they had attended mandatory training.
- For further detail regarding manadatory training, please see the Safe section in the surgery report.

Nursing staffing

- For further detail regarding nurse staffing, please see the Safe section in the surgery report.

Medical staffing

- For further detail regarding medical staffing, please see the Safe section in the surgery report.

Assessing and responding to patient risk

- Staff did not routinely use early warning scores within outpatient areas. If a patient became unwell, during their attendance, staff escalated to consultants who were on hand to treat deteriorating patients immediately.
- The service had procedures to transfer patients to the local emergency department for those needing emergency care.
- For further detail regarding assessing and responding to patient risk, please see the Safe section in the surgery report

Emergency awareness and training

- For further detail regarding emergency awareness and training, please see the Safe section in the surgery report.

Are outpatients and diagnostic imaging services effective?

We do not rate effective for outpatient services in independent heath settings.

Evidence-based care and treatment

- The service conducted local audits for example, infection control and medical records audits. Records we reviewed confirmed that managers shared results with staff.
- Consultants led and made decisions on care and treatment based on clinical evidence. This ensured consultants avoided discriminating against patients on the grounds of age, gender, disability and sexual orientation.
- For further detail regarding evidence-based care and treatment, please see the Effective section in the surgery report

Pain relief

Good

Outpatients and diagnostic imaging

- Records we reviewed confirmed that the service completed pain relief audits to ensure that all patients receiving treatment at the clinic did not experience pain or excessive discomfort.
- Pain relief audits were undertaken yearly. We saw from the audit completed in 2016 that 100% of patients (21 in total) who had undergone eye lid surgery found the pain medication advised was adequate to ensure they slept the night after surgery and did not complain of pain when called post operatively.
- For further detail regarding pain relief, please see the Effective section in the surgery report

Nutrition and hydration

- For further detail regarding nutrition and hydration, please see the Effective section in the surgery report.

Competent staff

- There was a process in place to ensure that all staff employed at the service had the right qualifications, competence, skills and experience necessary in order for them to carry out their role within the organisation.
- We saw that staff files contained competencies attained in order for them to be competent and confident in carrying out their duties.
- The registered manager told us staff had one to ones with line managers on a monthly basis as part of ongoing support to staff. This was confirmed by the staff records we reviewed and staff we spoke with.
- For further detail regarding competent staff, please see the Effective section in the surgery report.

Access to information

- Staff had all the information necessary to deliver care and treatment. Records we reviewed confirmed that the service had processes in place, to make patient records available in a timely and accessible way.
- Staff we spoke with confirmed that they had access to the information they needed to provide appropriate care and treatment to patients.
- For further detail regarding access to information, please see the Effective section in the surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke with understood their roles and responsibilities with regards to consent. We observed the clinic had forms and procedures to document patient consent to treatment. We saw in all patient records consent forms were present, signed and dated.
- For further detail regarding consent, please see the Effective section in the surgery report.

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

- Staff we spoke with described their passion for providing good patient care and building relationships with long-term patients. Staff were respectful and allowed patients plenty of time for discussion and questions. We saw positive and friendly interactions between staff and patients.
- The service participated in the Family & Friends Test (FFT). Of those who responded, 100% of patients would recommend the service to their friends and family. The average response rate for January to March 2017 was 59%.
- We saw that staff respected patient confidentiality and ensured discussions took place in treatment rooms for privacy. All patients we asked reported that their dignity and privacy was maintained throughout their stay. At reception patients could choose not to discuss any details at the reception desk and there was a side room available for sensitive discussions.
- Patients knew who to contact if they were worried or had further questions. Staff provided patients with phone numbers they could call during the day and out of hours. All patients we spoke with said they were either confident they could call someone or had already used the phone number if they had concerns.
- We received 11 'tell us what you think cards' from patients receiving treatment at the service. All comments were extremely positive regarding the care they had received at the clinic.
- For further detail regarding compassionate care, please see the Caring section in the surgery report.

Understanding and involvement of patients and those close to them

Good

Outpatients and diagnostic imaging

- All patients we spoke with said the consultants gave them enough time during their appointments, to ask questions and find out more information. Patients and relatives said they felt involved and informed about their care and treatment.
- All staff we spoke with, understood patient's personal commitments and we saw examples of staff attempting to fit appointments around patient lifestyles and commitments such as work or children.
- Staff had appropriate and sensitive discussions with self-funding patients regarding cost of treatment. Staff provided patients with treatment options including any attached costs. Staff conducted conversations in private and away from waiting areas.
- For further detail regarding understanding and involvement of patients and those close to them, please see the Caring section in the surgery report.

Emotional support

- All patients we spoke with said they were involved in their care and treatment. Patients told us that they were provided with choices in terms of the next steps in their treatment pathway. All of the patients we spoke with told us that they had been provided with information detailing the possible positive and negative impacts on any option of treatment and care.
- One of the patients we spoke with said; " I couldn't get the help I have gotten here in Europe or America, I have been so well cared for and looked after. I have nothing but positive things to say about everyone here." Another patiet told us; " I could not have been better looked after, every time I've been here everyone has been lovely. I have total faith in all the doctors and staff here."
- For further detail regarding emotional support, please see the Caring section in the surgery report.

Are outpatients and diagnostic imaging services responsive?

Good

Service planning and delivery to meet the needs of local people

- The service offered clinics at a variety of times throughout the day, from Monday to Friday to fit in with patient's needs.
- The environment was bright and spacious and waiting rooms had comfortable seating and refreshments. We observed there were appropriate facilities for disabled access including ramps and a lift.
- For our detailed findings on service planning and delivery to meet the needs of local people for this core service please see the Responsive section in the surgery report.

Access and flow

- Patients were able to arrange OPD appointments via a range of means. Self-paying and insured patients were able to self-refer without a GP or optician's referral.
- We observed staff try to make sure that patients got an appointment of their choice, sometimes on the day of referral. We saw one patient call the service and were offered several different appointments. Another patient spoken with said they were please as to how fast they got an appointment.
- The service audited patient waiting times for consultations in 2016.This highlighted that two consultants regularly over ran on their allocated patient appointment times. We were told although no patients complained, reception staff had commented that they felt this was becoming a problem. Discussion of the results with the doctors concerned resulted in extended appointment times. A three month follow up audit revealed that waiting times had been significantly reduced. We were told that the usual waiting time to see the consultant was five minutes.
- We observed patients in the waiting room and those we spoke with told us they had not had to wait long before being called for their appointment.
- For our detailed findings on access and flow please see the Responsive section in the surgery report.

Meeting people's individual needs

- The waiting area was spacious and allowed for easy access by wheelchair users. There were separate offices that supported staff and administrators to have private discussion if required. The services also had confidential interview and clinic rooms, which enabled staff and patients to have private discussions.
- Staff offered patients drinks while waiting for appointments. We noted that there was a coffee machine and water dispensing machine in the waiting area.

Good

Outpatients and diagnostic imaging

- We spoke with staff and patients who informed us that there was assistance for people who required additional support to communicate such as a loop system to assist in hearing and a translation service for patients who would benefit from these services.
- We noted that information was available to patients about who to contact if they had any concerns about their care. Additionally there was a wide variety of information leaflets available in both waiting areas. We asked staff and patients if information was available in different formats such as braille, large print or other languages. Staff and management confirmed that different formats were available if requested but were not readily available on site.
- For our detailed findings on meeting people's individual needs please see the Responsive section in the surgery report.

Learning from complaints and concerns

- The service had a complaints policy in place, this was in date, reviewed and updated regularly and was accessible to staff.
- The outpatient department displayed their complaints leaflet that informed patients of how to complain.
- For our detailed findings on Learning from complaints and concerns for this core service please see the Responsive section in the surgery report.

Are outpatients and diagnostic imaging services well-led?

Good

Leadership and culture of service

- There was no separate manager for the outpatients department. The registered manager also oversaw the management of this department.
- All staff spoken with in OPD told us that they felt very well supported and enjoyed working at the clinic.
- Staff we spoke with who worked in Outpatients Department (OPD) told us that they were aware that providing quality care was important to the service.
- For our detailed findings on leadership and culture of service please see the Well led section in the surgery report.

Vision and strategy for this core service

- All staff members we spoke with in OPD were aware of the vision and strategy of the service.
- For our detailed findings on vision and strategy for this core service please see the well led section in the Surgery report.

Governance, risk management and quality measurement

- The provider had an effective system in place to identify, monitor, manage and mitigate risks within OPD.
- All staff members we spoke with in OPD were aware of the governance arrangements. They described how management checked the quality of the service and informed them of where improvements needed to be made.
- There was evidence of governance meetings, where managers discussed and reviewed risks and incidents. Staff we spoke with and copies of the minutes reflected that OPD staff attended service-wide meetings.
- For our detailed findings on governance, risk management and quality measurement for this core service please see the well led section in the surgery report.

Public and staff engagement

- For our detailed findings on public and staff engagement for this core service please see the Well led section in the surgery report

Innovation, improvement and sustainability

- For our detailed findings on innovation, improvement and sustainability for this core service please see the well led section in the surgery report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The service should take action to provide medical advisory committee meetings to ensure the wider medical team are regularly updated as to their performance and review outcomes for their patients.

The service should consider further the use of an independent complaints adjudication service to support patients should they need to complain.

The service should take action to provide secure access to the theatre.

The service should take action to provide a system of assurance that they have an accurate record of all staff who have read and understood policies, procedures and risks within the service.