The Stratford Clinic

Quality Report

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Date of inspection visit: 12 December 2018
Date of publication: 11/02/2019

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

The facility provides a range of surgical procedures and outpatient services. We inspected both the surgical and the outpatient services. Services include day-case surgical procedures and outpatient appointments for preoperative and postoperative review, as well as outpatient treatments such as joint injections, cryotherapy and mole mapping. In the reporting period of October 2017 to November 2018, there were 333 day-case episodes of care and 2434 outpatient attendances. The outpatient appointments were a mixture of patients accessing treatment and surgery outpatient consultations.

We inspected this service using our comprehensive inspection methodology. We carried out the short notice announced inspection on 12 December 2018.

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

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

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

Services we rate

Our rating of this hospital/service improved. We rated it as good overall.

Infection risks were controlled well. Staff were aware of the need to maintain a clean environment and kept equipment and the premises clean.

There was enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Staff recorded and administered medicines well, the clinic provided adequate storage and had processes in place for the monitoring of medicines.

Staff were competent for their roles. The clinic manager appraised staffs' work performance and held training sessions to provide support.

All relevant staff were involved in assessing, planning and delivering people's care and treatment. Treatment was consultant-led and involved discussions with the nursing staff and administrative staff where required.

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Services were planned and provided in a way that met the needs of local people and considered meeting peoples individual needs.

Leaders within the clinic had the skills, knowledge and experience required to run a service providing sustainable care.

However:

Summary of findings

There were systems in place to ensure the safety of patients. However, we found inconsistencies with the completion of observation charts.

Care and treatment was provided based on national guidance there was evidence of its effectiveness. However, we saw that some policies were not available.

Staff generally used care pathways to ensure best practice was followed however we were told by the registered manager that the clinic was currently evaluating the venous thromboembolism (VTE) policy.

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

Amanda Stanford
Acting Deputy Chief Inspector of Hospitals (Central)

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 hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Outpatients	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.

Summary of findings

Contents

Good

The Stratford Clinic

Services we looked at
Surgery; Outpatients

Summary of this inspection

Background to The Stratford Clinic

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

The clinic manager had been in post since March 2017 and became the registered manager with the CQC in August 2018.

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

We carried out a short notice announced inspection on 12 December 2018.

Our inspection team

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

Information about The Stratford Clinic

The main service at the clinic was surgery. All surgery was performed under local anaesthetic or conscious sedation. Pre-operative and post-operative consultations were undertaken at the clinic, for surgery that was performed by the consultants at the clinic and at other local private hospitals. All patients were operated on and went home the same day, there were no overnight stays. The other service provided was outpatients. Outpatient treatments, for example; joint injections, cryotherapy, mole mapping and photodynamic therapy were also provided by consultants. Only patients aged over 18 years were seen at the clinic.

There were four consultation rooms, one operating theatre, and a recovery area. SWFT is registered to provide the following regulated activities:

• Treatment of disease, disorder or injury

• Surgical procedures

• Diagnostic and screening procedures.

During the inspection, we visited all the consulting rooms, the recovery area and the operating room. We spoke with six staff including the clinic manager, the executive director, a consultant, registered nurses and a receptionist. We also spoke with three patients and reviewed 15 sets of patient records.

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

Activity (October 2017 to November 18)

- In the reporting period of November 2017 to October 2018, there were 333 surgical procedures performed.
- In the reporting period of November 2017 to October 2108, there were 2434 outpatient appointments.
- In the reporting period of November 2017 to October 2018, 0% of patients were NHS funded. The clinic stopped treating NHS patients in August 2017.
- In the reporting period of November 2017 to October 2018, 0 patients under the age of 18 attended the clinic. The clinic stopped treating patients under the age of 18 in August 2017.

Summary of this inspection

There were 12 consultants working under practising privileges. The service also employed a registered clinic manager, four registered nurses and a receptionist.

Track record on safety

- Zero never events

- Four clinical incidents which resulted in no harm

- Zero serious injuries.

- Zero incidences of healthcare associated MRSA.

- Zero incidences of healthcare associated Methicillin-sensitive staphylococcus aureus (MSSA).

- Zero incidences of healthcare associated Clostridium difficile (C. difficle).

- Zero incidences of healthcare associated Escherichia coli (E-Coli).

- Zero complaints

Services provided at the clinic under service level agreement:

• Clinical and non-clinical waste removal

• Maintenance of medical and specialist equipment

• Pathology

• Sterile services

• Domestic cleaning service

• Fertility services

• Pharmacy services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **Good** because:

- Mandatory training in key skills was provided to the nursing staff. There were processes in place to monitor training compliance and ensured everyone completed it.
- Staff understood how to protect patients from abuse and had access to safeguarding policies for adults.
- Infection risks were controlled well. Staff were aware of the need to maintain a clean environment and kept equipment and the premises clean.
- The premises and equipment were suitable for purpose and looked after well.
- There was enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- Staff recorded and administered medicines according to best practice. There was adequate storage and processes in place for the monitoring of medicines.
- Patient safety incidents were managed well. Staff recognised incidents and reported them appropriately. The clinic manager investigated incidents and shared lessons learned with the whole team. There were systems in place to ensure the safety of patients.
- Records were kept in locked cupboards to maintain confidentiality.
- There were systems in place to ensure the safety of patients.

However:

- Staff generally kept appropriate records of patients' care and treatment.
- Equipment, was not marked with a sticker to confirm cleaning had been undertaken between patients, this meant staff did not always have assurance that equipment had been cleaned before use.
- The resuscitation trolley was not tamper proof this meant that emergency equipment could be removed from the emergency trolley.

Are services effective?

Good

We rated effective as **Good** because:

- Patients' pain was managed effectively and pain relief was provided as needed.

Summary of this inspection

- The clinic manager monitored the effectiveness of care and treatment and used the results to improve them.
- Audits were completed to ensure staff followed guidance and progress was monitored
- Staff gave patients enough food and drink to meet their needs.
- Staff were competent for their roles. The clinic manager appraised staff's work performance and held training sessions to provide support.

However:

- Not all policies were updated and reflected clinic practice.

Are services caring?

Good

We rated caring as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.

Are services responsive?

Good

We rated responsive as **Good** because:

- Services were planned and provided in a way that met the needs of local people. The importance of flexibility and choice was reflected within the practice of the clinic.
- Patients' individual needs were considered. All admissions were pre-planned so staff could assess patients' needs before their treatment.
- Patients could access the clinic when they needed it. Waiting times from treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Concerns and complaints were treated seriously, investigated and lessons learned from the results, which were shared with all staff.

Are services well-led?

Good

We rated well-led as **Good** because:

- Leaders within the clinic had the skills, knowledge and experience required to run a service providing sustainable care.
- There was a positive culture in the clinic, where staff were supported and valued

Summary of this inspection

- The quality of services were improved by creating an environment in which excellence in clinical care would develop.
- There were systems in place to identify risks, plans to eliminate or reduce them, and cope with both the expected and unexpected.
- There was a commitment to improving services. Lessons were learnt when things went well or wrong, promoting training, research and innovation.

However:

- The clinic did not have a vision for what it wanted to achieve. During this inspection the managing director and clinic manager explained that due to financial constraints on the business, SWFT Clinical Service Ltd, was looking in to other viable options in relation to their healthcare division. Therefore, they were unable to provide a vision and strategy for the clinic at the time of our inspection. Staff were aware that the clinic was undergoing a new structure.

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	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Are surgery services safe?

Good

Our rating of safe improved. We rated it as **good.**

Mandatory training

- **Mandatory training was provided in key skills to the nursing staff. There were processes in place to monitor training compliance and ensure everyone completed it.**
- **Mandatory training included intermediate life support training, manual handling, health and safety, fire safety, infection prevention and control, information governance, anaphylaxis, medicines management, conflict resolution, dementia, equality and diversity, waste management, and safeguarding training. Overall staff compliance was 93.4% at the time of our inspection.**
- There was a training matrix record on the staff notice board, which was monitored by the clinic manager, who reminded staff to complete their training online or arranged face-to-face training with the relevant training lead at a local NHS trust.
- During our inspection we were told that the team had recently arranged manual handling training to be completed at the clinic site rather than at the local trust, this meant that the training was delivered specifically for the clinic environment.
- On our previous inspection we highlighted that the consultants did not receive mandatory training provided by the clinic, however this was provided by their other places of employment, usually their NHS trust. We did not see any evidence on this inspection, that training had been completed in line with mandatory requirements as training records were held offsite. We were told the clinic could access to these records if necessary. However, we saw evidence that their professional qualification with the General Medical Council had been checked and that yearly appraisals had been completed.

Safeguarding

- **Staff understood how to protect patients from abuse and had access to safeguarding policies for adults.**
- There was no designated lead for safeguarding at the clinic. However, staff had access to a local NHS trust's safeguarding lead for adults, for advice. Staff told us they would discuss any concerns with the clinic manager and report them as an incident. This was in line with the responsibilities of all staff outlined in the safeguarding policy.
- On our previous inspection we established that the staff had not received safeguarding level two training, which did not meet the national requirements, set out by the Royal College of Paediatrics and Child Health (RCPCH) in 'Safeguarding children and young people.' However, on this inspection we found all nursing and administrative staff had completed both adults and children safeguarding level one and two. The clinic had not provided any services to children and young adults under the age of 18 since August 2017.
- On our previous inspection we found that not all staff had a valid disclosure and barring service (DBS) certificate, however the staff records we reviewed on this inspection confirmed in date DBS certificates.

Cleanliness, infection control and hygiene

- **Infection risks were well controlled. Staff were aware of the need to maintain a clean environment and kept equipment and the premises clean. However, it was not always clear when some equipment had been cleaned.**
- We saw staff complying with infection prevention and control policies. For example, we saw two members of staff wash their hands and one member of staff use alcohol hand sanitiser in accordance with the World Health Organisation (WHO) 'five moments for hand hygiene'. We saw hand sanitiser bottles readily available throughout clinical areas in theatres, recovery room and outpatient areas.
- Staff in the theatre environment followed prevention and treatment of surgical site infection in line with the National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection. This included the use of surgical skin preparation to clean the patients' skin and that any surgical wounds were clean and covered to minimise the risk of infection.
- Disinfectant wipes were readily available for cleaning hard surfaces and equipment surfaces in between each patient, and we witnessed staff using these. Clean linen was stored appropriately and readily available in the clinic.
- The theatre, recovery room and outpatient areas were visibly clean, and there was a safe 'flow' from clean to dirty areas to minimise the risk of cross contamination of equipment.
- Waste in all clinical areas was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, management and disposal of healthcare waste. The clinical waste unit was secure and all clinical waste bins we checked were locked.
- We observed that sharps management complied with Health and Safety (sharp instruments in healthcare) Regulations 2013. We checked three sharp bin containers which were all clearly labelled, to ensure traceability and lids were in the closed position to ensure items within were stored safely.
- There were daily cleaning schedules in theatres, recovery and the outpatient areas. We saw these were fully completed in accordance with the clinic operating procedure guidance.
- The operating theatre was compliant with Health Technical Memorandum (HTM) 03-01 specialist ventilation for healthcare premises. This meant there were an adequate number of air changes per hour, which reduced the risk of infection. However, the clinic manager informed us that there had been an incident relating to inadequate air changes. Surgical procedures had been postponed until the ventilation unit was repaired.
- On our previous inspection we saw that dirty instrumentation was washed at the clinic and frequently left over long periods prior to being transferred to the local trust for sterilisation. On this inspection we saw that all dirty instrumentation was sprayed with a special cleaner and stored in a sealed bag, which was then placed in a sealed plastic box awaiting transfer to be sterilised, all staff used personal protective equipment such as goggles whilst undertaking this process. Decontamination and sterilisation of instruments was managed in a dedicated facility offsite, which was compliant with HTM 01-01. The facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres and clinics. The clinic used single use surgical instrumentation equipment where possible.
- During this inspection we noted that a deep clean had been completed within the theatre environment, every six months since January 2018. This is in line with the recommended infection prevention practice. The clinic had an outsourced cleaning agreement with a local company. A service level agreement was in place to ensure all necessary standards were met.
- Sterile instruments were previously stored in a closed cupboard with no ventilation or temperature control. On this inspection we saw that all sterile instrumentation was kept in a well-ventilated room where the humidity and temperature was recorded daily.
- We observed staff cleaning equipment, however, it was not marked with a sticker to confirm this. This meant staff did not always have assurance that equipment was clean before use.
- Hand hygiene audits in October 2018 showed 100% overall compliance with hand hygiene.

Environment and equipment

- **Premises and equipment was suitable for purpose and was looked after well.**
- The clinic had an accessible resuscitation trolley. This was stored between the theatre and the recovery room, this was an area that patients walked through. We observed that the trolley drawers which contained

equipment and drugs were not tamper proof. This meant that there was a risk of equipment being used or damaged without staff knowledge. The individual medicine boxes contained the manufacturer's tamperproof seal so staff could see if the box had been opened and one of the medicines used. There was a checklist of contents and expiry dates. We reviewed the checking of resuscitation equipment and saw that they were completed daily in line with the clinic policy. All equipment was in date and the clinic staff had received the appropriate level of resuscitation training.

- The facilities and premises were well maintained. The clinic was located on the ground floor and had adequate disabled access. Flooring within the clinic was compliant with Health Building Note (HBN) 00/ 10 Part A Flooring (DH 2013). 2.9 which states that there should be a continuous return between the floor and the wall, for example coved skirting with a minimum height of 100mm for easy cleaning.
- The Electricity at Work Regulations 1989 require that any electrical equipment that has the potential to cause injury is maintained in a safe condition. Appliance testing stickers were observed on all essential items of equipment.
- Equipment within the clinic was well maintained. There was an electronic database of all equipment, which showed that all had been serviced and electrically safety tested within recommended timeframes.
- A health and safety audit was completed monthly. We saw that there had been actions taken as a result of this audit, for example, there had been a concern following a staff member falling from a swivel chair. Following this, fixed castors were obtained to avoid a similar incident happening in future.

Assessing and responding to patient risk

- **There were systems in place to ensure the safety of patients.**
- Patients completed a pre admission questionnaire to assess if there were any health risks, which may have compromised their treatment at the unit. Nurses discussed the health questionnaires with patients in the pre-admission clinics or via the telephone. If staff identified a patient as being at risk, they were not accepted for surgery.
- VTE assessment checklists were contained within patient notes, however we found that out of 15 records only four VTE assessments had been completed. We raised this with the clinic manager who stated they did not always do them as they were not necessary. The clinic had a policy in place which stated that due to the low risk associated with the patient's surgery they deemed VTE assessments were not always necessary. This was in line with the Department of Health day case guidelines 2010 Patients undergoing ophthalmic and dermatology procedures were deemed to be low risk.
- The clinic had an unplanned transfers policy, which was in date. The policy set out the actions that should be taken if a patient became unwell and required transfer to an acute hospital. The clinic reported there had been no unplanned transfers of a patient to another unit in the reporting period of November 2017 to October 2018.
- Staff met for a 'team briefing' at the start of each operating list in accordance with the World Health Organisation, 'Five steps to safer surgery'. We observed one team briefing, which was comprehensive and discussed each patient, to minimise any potential risk. Pre-existing medical conditions and allergies were discussed to ensure all the team were aware. Equipment requirements were also discussed and we witnessed the consultant surgeon checking additional equipment. The briefing demonstrated that risks were discussed and any potential issues were highlighted.
- Postoperative checks were completed by the operating surgeon. Anaesthetists stayed in the clinic following any procedures that had been done under sedation. This maintained patient safety and continuity of care.
- A copy of an adapted WHO checklist was in each patient's notes, but they were not always fully completed and each checklist we reviewed varied. This finding was similar to our previous inspection. We reviewed three checklists and found some had signatures of staff members who were present in theatre and others had names handwritten by one person, despite this, it meant that evidence could be provided to exhibit adequate staffing levels within the theatre.
- The clinic offered day case surgery under local anaesthetic. However, patients were offeredsurgery under local anaesthetic with sedation, for procedures such as liposuction with fat transfer. On these occasions, a consultant anaesthetist was available and remained in the clinic until the patient had been discharged. From January 2018 to November 2018, two procedures had been performed using sedation.

- Pre-operative risk assessments were completed for all patients. Patients were asked about their previous medical history. No blood tests were performed due to the nature of the procedures the clinic offered.
- On our previous inspection, needle, swab and instrument counts were not completed in line with recognised guidance. However, on this inspection we saw that theatre staff completed the pre and post surgical checks in line with the Association for Perioperative Practice (AfPP) guidelines. The counts were clear and concise, all correct checks were documented within the theatre pathway.
- There was a process for identifying a deteriorating patient; for example, patients who had been administered sedation. Observations such as blood pressure, pulse, nausea, surgical bleeding and pain scores were completed. We saw that observations were completed within patient records.
- Once patients were stable and pain-free and able to be discharged, staff contacted the responsible adult who was able to collect, escort and stay with them for 24 hours post operatively. We saw in the patients care plan there was a section to be completed with the nominated adult's name and contact details. This ensured staff were aware who to contact when the patient was fit for discharge.
- All patients received a welfare courtesy call the day after surgery, from a nurse. If any concerns were raised during this call, they were escalated to the surgeon. The nurse had a post-operative phone call checklist, which included discussions around the use of pain relief, eye drops, eye care, vision status, and whether the patient felt lightheaded or dizzy.

Nursing and support staffing

- **There was enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.**
- The clinic employed four registered nurses and a receptionist. There was also a clinic manager. Bank nurses and agency operating department practitioners were allocated shifts when they were required.
- There were no staffing tools in place to ensure that staffing levels were sufficient to meet patient acuity and dependency. However, a minimum staffing level standard operating procedure was in place and adhered to.
- On inspection, we saw that staffing levels were sufficient, with each patient being attended to by a surgeon and two registered nurses whilst in theatre. This met the Association for Perioperative Practice (AfPP) 2014 guidelines; Staffing for patients in the perioperative setting. There was one registered nurse allocated to admit, discharge, and care for patients whilst in recovery.
- The maximum number of patients a registered nurse would care for post-operatively was two at any one time. Nurses felt this was manageable.
- Nursing handovers were not necessary as nurses were required to work for the duration of a surgical list.

Medical staffing

- Medical staffing levels were appropriate for the procedures performed at the clinic.
- There were 12 consultant surgeons and one anaesthetist working at the clinic under practising privileges.
- As all patients were either outpatients or had their procedure done as a day-case, there were no handovers or shift changes. The consultant surgeon remained with the patient until discharge.

Records

- **Staff generally kept appropriate records of patients' care and treatment. Records were kept in locked cupboards to maintain confidentiality.**
- There was a records audit undertaken by the clinic each month. Patient documentation audit for the month of October 2018 showed 96% compliance. The record audit included criteria, for example:

  - Correct patient information

  - Known allergies have been recorded

  - Fully completed and signed consent form

- We reviewed 15 records and saw that there was no standardised process when filing them. We were told by clinic staff that navigating through files was could be problematic and time consuming. However, we saw that all records had the relevant information relating to the patient and their procedure.
- Patients' records were paper-based and stored securely. However, the clinic did not have a copy of all records for patients that had been seen at the clinic as some were taken away by the consultant, although these were

available if required. A copy of all surgical procedure notes were stored in locked cabinets. Clinic notes were completed for each patient, which then remained within the clinic to allow access to information when required for appointments. The clinic manager told us they had identified that consultants were not storing clinic notes in an appropriate way as they were being left in clinic rooms unfiled. Following this a process had been implemented to ensure each clinic note, was filed in a yellow document folder. We observed that this process had not been fully implemented for all clinic notes as some were still stored within plastic wallets.

- We saw the theatre records section of care plans were clear and documented. Adapted WHO checks had been completed to ensure safe surgery and treatment was undertaken.
- Consultants were responsible for bringing their own patient records to the clinic on the day of their clinic or theatre list. Each consultant was registered as a data controller with the Information Commissioners Office (ICO).

Medicines

- **Staff generally recorded and administered medicines well, the service provided adequate storage and had processes in place for the monitoring of medicines.**
- We reviewed 15 medicine administration charts and saw that all medicines had appropriate staff signatures in line with the services policies and procedures. One patient had received a medicine used to treat and prevent blood clots, the time and dose was recorded, however, there was no documentation as to who had administered or prescribed this. Allergies were recorded correctly in all the records we saw.
- Information from the Private Healthcare Information Network (PHIN) showed that 94% of patients that felt they had been told about medication side effects to be aware of post operatively.
- Patients undergoing liposuction procedures were prescribed antibiotics following their surgery, to reduce the risk of post-operative infections. Blank prescriptions were stored in a locked drawer. This was in line with guidance from NHS counter fraud authority which recommends that prescription forms should be kept in a locked cabinet within a lockable room.
- On our previous inspection we noted that controlled drugs were not routinely stored within the clinic and were obtained in an unsecure manner from another provider, which was a breach of regulation. However, on this inspection was saw that controlled drugs were ordered, stored and administered in line with recognised legislation. We saw that all controlled drugs that were ordered and received were signed for by registered nurses and were then counted and signed into the clinic's controlled drug book. All drugs and books were stored within a locked cupboard in the operating theatre.
- Medicines requiring refrigeration were stored appropriately and temperatures were checked daily. We also saw records of the daily checks of ambient room temperatures and found they had been completed.
- Emergency medicines were stored within a sealed box. The sealed box was checked to ensure the medicines had not expired and that the box remained tamper free. On our previous inspection we found that the emergency medicines were stored within the operating theatre which meant they were not readily accessible in the event of an emergency. However, on this inspection we found that the emergency drug box had been allocated in a staff area central to all clinic facilities. The staff area was only accessible to the clinic employees. An audit of medicines storage and handling was completed by the local trust's pharmacy manager. The clinic scored 93.3%, we saw that the clinic manager had reviewed the audit and there was evidence of learning. Actions taken from the audit included the calibration of thermometers used within the clinic areas.

Incidents

- **The clinic managed patient safety incidents well. Staff recognised incidents and reported them appropriately. The clinic manager investigated incidents and shared lessons learned with the whole team.**
- Staff used an electronic incident reporting tool to record incidents. Staff had received training on how to report incidents.
- From January 2018 to November 2018, 16 incidents were reported. Three of these incidents were clinical and the remaining 13 were non-clinical. The clinical incidents were all graded as no harm and had appropriate actions noted to demonstrate actions taken and steps to avoid risk of harm in future. There were two incidents relating to breach of patient data, these had both been investigated fully. One of these incidents was

the result of a consultant following incorrect procedures; from the investigation it was noted this consultant was still declining to follow the correct procedure despite a breach being identified however steps had been taken by the clinic manager to ensure that correct procedure was followed.

- During our last inspection we found the clinic was using an incident management policy that was had been devised and managed by a local NHS trust. The policy did not reference The Stratford Clinic within the document and did not reflect the clinic's procedures accurately. We observed that a bespoke incident management policy was in the process of being ratified.
- People who used the services were always told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result, according to Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations or duty of candour. For independent providers it came into effect in April 2015. Staff were aware of the duty of candour and could explain the steps they would take regarding apologising to the patient, including being open and transparent about any failings in their care.
- We saw evidence that duty of candour had been applied for most required incidents. However, we found one incident where a patient's data had been shared with another patient. The patients whose data had been breached were contacted and received an apology.
- Lessons were shared to make sure action was taken to improve safety. Senior team meetings, staff meetings and staff debrief meetings were held where any learning from incidents was shared.
- Daily informal conversations were held with staff regarding issues and incidents. Incidents were also discussed at monthly staff meetings where staff were encouraged to read the summary of incidents in order to learn from them.

Safety Thermometer (or equivalent)

- The safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to unit inpatients. These include falls, new pressure ulcers, catheter and urinary tract infections (UTIs) and venous thromboembolism (VTE) (blood clots in veins). The clinic did not submit data as part of this national programme.

Are surgery services effective?

Good

Our rating of effective improved. We rated it as **good.**

Evidence-based care and treatment

- **The clinic provided care and treatment based on national guidance and evidence of its effectiveness. Audits were completed to ensure staff followed guidance and progress was monitored, however a small number of policies had not been updated to reflect clinic practice.**
- On our previous inspection in December 2017, we saw that policies did not reflect the clinic practice as they had been developed by the local NHS trust. During this inspection we saw that most policies had been updated and reflected the clinic's practice, however some policies were still in the process of being written, for example information governance, data protection and incident management.
- Clinic staff confirmed they could access the clinic's policies either via the intranet or by quick reference paper copies, which were available in the staff area. Policies we reviewed referenced up to date relevant national guidelines and best practices.
- Staff generally used care pathways to ensure best practice was followed. Care pathways are a method of using a focused approach to care, which standardises care and treatment. For example, an eye surgery pathway was designed to specifically assess risks associated with these procedures.
- We were told by the registered manager that the clinic was currently evaluating the VTE policy to ensure up to date NICE guidance was being used to ensure patients were receiving the most up to date care to comply with best practice.
- The clinic received notifications from NICE and the National Patient Safety Agency detailing updated guidance and quality standards. Notifications were reviewed by the clinic manager and if they were relevant to services provided at the clinic, policies and standard operating procedures were updated. This was communicated to staff during monthly staff meetings.

- The service did not participate in the Anaesthesia Clinical Services Accreditation scheme. Anaesthesia Clinical Services Accreditation is a voluntary scheme for NHS and independent sector organisations that offers quality improvement through peer review.
- The clinic collated and submitted data to the Private Hospitals Information Network (PHIN.) PHIN is a network system that provides information about private healthcare, that empowers patients to make informed choices about their preferred provider. The clinic provided information to PHIN on a quarterly basis, which included patient satisfaction survey results and patient reported outcome measures from cataract surgery, which was reviewed on a regular basis by the clinic manager and acted on when required.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs.**
- Patients' nutrition and hydration needs were met. Patients were offered hot and cold beverages and snacks following their day case procedures. There were no facilities for meals or to cater for special diets, however, the clinic's work did not dictate that this was necessary.
- Prior to surgery patients were asked when they had last consumed food and drinks. They were advised to withhold food for six hours before surgery and clear fluids two hours before surgery. This was in line with Royal College of Anaesthetists guidance.

Pain relief

- **Patients' pain was managed effectively and pain relief was provided as needed.**
- Patients had surgery under local anaesthetic or conscious sedation and any pain they had after their procedure was managed well.
- Patients who experienced pain in recovery were offered pain killing medication. Staff told us this rarely happened and they were rarely required to provide pain relief. Medicines to take home included pain relief when necessary.
- During our inspection we observed a consultant surgeon advising the patient with regards to post-operative pain relief.
- The clinic did not conduct pain relief audits. We were told that patients did not complain about pain due to the type of procedures being performed. Patients were asked about pain prior to discharge and again over the telephone the following day.

Patient outcomes

- **The clinic manager monitored the effectiveness of care and treatment and used the results to improve them.**
- The clinic had an effective system to regularly assess and monitor the quality of its service to ensure patient outcomes were improved. Clinical audits and risk assessments were carried out. The clinic participated in some national audits to monitor patient outcomes including the PROMs programme and PHIN.
- The clinic participated in national audits such as PHIN which showed information regarding patient satisfaction, patient experience and health outcomes which were rated as 97%, 98% and good respectively.
- Local audits were completed and actions taken were detailed for each audit where necessary. The clinic ensured that if the audit compliance was not above 95%, re auditing would take place either monthly or weekly until necessary standards had been reached and embedded. For example, the theatre debrief audit had been evaluated at achieving 80% compliance, therefore the audits had been carried out weekly until compliance had reached above 95%.
- Patients were encouraged to complete patient satisfaction surveys following their day case surgery. Results from patient satisfaction surveys were reviewed and discussed at the quarterly clinical governance committee meetings.
- Each patient survey was reviewed by the clinic manager to act on patients' feedback. Consideration was given to improving processes and applying new practices to improve patient care and outcomes.
- Due to low levels of activity the clinic did not obtain sufficient amounts of data to benchmark with peer organisations.
- There were no unplanned readmissions within 28 days of discharge in the reporting period form November 2017 to October 2018.
- Consultants were sent, monthly, a form to complete any incidences of post-operative infections, returns to

theatre and adverse events, when completed these were forwarded to the clinic for monthly review and reporting to the clinical and quality governance committee which met on a quarterly basis.

Access to information

- **Staff had access to the information they needed to deliver effective care and treatment to patients**.
- Staff told us information needed to deliver effective care and treatment was available to relevant staff in a timely manner. A copy of all surgical procedure notes were stored in locked cabinets.
- All staff were familiar with the clinics electronic patient booking system and could navigate it well. We observed the receptionist, nurses and the clinic manager using the administration system. Clinic notes were not electronic however information could be accessed easily if required through a request to the consultant's secretary.
- Records of patients who had received intravitreal injections, pre-operative assessments or consultations at the clinic were kept by the consultants. Clinic staff were able to access this information.
- The clinic manager told us that all patients seen within surgery had all their relevant medical records available. The unavailability of records had been identified as a potential issue and a risk assessment had been completed. We saw on this inspection that the risk had been reviewed and risks mitigated.
- All staff had access to a local NHS trusts intranet. They could access the trust's policies, pathways and best practice guidance via the intranet. Staff told us they used this regularly.

Competent staff

- **Staff were competent for their roles. The clinic manager appraised staffs' work performance and held training sessions to provide support.**
- Staffs' work performance was assessed using an annual appraisal system. All staff told us that they had received an appraisal within the past year – compliance was 100%. Staff were allocated time to complete mandatory or other training along with continuous professional development time. This was scheduled into the staff rotas.
- Some clinic nurses had received further training to perform ophthalmic tests such as visual field analysis and visual acuities. Many patients who attended on a regular basis for on-going treatment saw the same team of nurses which helped with continuity of care.
- Consultants and nursing staff attended conferences regularly to ensure their practice was up to date. Nursing staff were asked to feed back to the rest of the team on any courses they had attended. Learning files were available for different procedures and specialities which encouraged continuing professional development.
- All consultants worked under practising privileges. The clinic manager completed yearly checks of indemnity insurance, appraisals and GMC registration checks. During our previous inspection we saw no evidence of consultants' scope of practice, mandatory and safeguarding training. Although we saw scope of practice during this inspection, there was no evidence of training records., however these were available on request from the local NHS trust where the consultants currently worked.

Multidisciplinary working

- **All relevant staff were involved in assessing, planning and delivering patients' care and treatment.**
- Treatment was consultant-led and involved discussions with the nursing staff and administrative staff where required.
- The team worked well together, providing care to patients. There were positive working relationships between the both administrative staff and the clinical team.
- Discharges were facilitated by nursing and medical staff who worked together to ensure the patient was fit to go home.
- Relevant information, for example details of surgery and medicines that had been taken home was shared between the clinic and the patients' general practitioner (GP). This was in order to maintain a full chain of records.
- Patients who had undergone cataract surgery had the details of their surgery sent to their optometrist.
- There were service level agreements (SLAs) in place with a number of organisations including a local NHS trust. There were positive working relationships between staff

and the local NHS provider who regularly provided advice to staff when required. Staff from the local trust carried out audits, provided sterile services and pharmacy support to the clinic.

Health promotion

- Patient information leaflets were assembled in conjunction with the most recent evidence based guidance and agreed with the relevant consultant before use. All patients who attended for day case surgery received a telephone call the next day to ensure they were comfortable and had understood all the information they were given.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the need for gaining valid consent from each patient. A consent policy and process was in place and written information including the risks and benefits of the proposed treatment or procedure, was given to the patients. The information was discussed with patients during their consultation.
- On our previous inspection we saw that consent forms were not being completed correctly. However, on this inspection all consent forms were found to be completed in line with clinic and national guidance.
- Previously we had found that there were different types of consent forms for different procedures, on this inspection all consent forms were the same.
- Patients were supported to make decisions by being given realistic expectations about the outcome of their surgery. The information leaflets, given to patients during their consultation, which discussed the risks and benefits were very thorough, to ensure that patients were fully informed and able to give consent accordingly.
- Patients were told of all possible risks and benefits of the procedure they were proposing to undertake. Realistic expectations were set, so that they understood what the outcome would be. This was in line with NICE guidance QS15 Statement 5.
- A two-week cooling off period for all procedures was usually maintained between a patient consenting to a procedure and undergoing surgery. Patients were encouraged to go away and think about the procedure and information given before coming back for their procedure.
- The rights of people subject to the Mental Health Act were protected. Staff were aware of what to do, if a patient had mental health concerns. Nurses and consultants had an awareness of how to undertake mental capacity assessments, in accordance with the Mental Capacity Act 2005. We saw that staff did not record if the patient had capacity, the clinic's consent policy stated that mental capacity would be assumed unless otherwise documented.

Seven-day services

- There were no seven-day services provided at the clinic.
- The clinic was open from Monday to Friday 8.30am to 6 pm. Evening appointments were available for patients when requested.
- Out of hours cover was provided by the consultants. The patients were given the consultants personal mobile number to contact if they became concerned following a surgical procedure.
- Evening and weekend consultation appointments were offered to patients to provide flexibility and choice. Procedures were also performed on Saturdays.

Are surgery services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- We observed staff members being courteous and helpful to patients and treated them with dignity and respect. Staff understood and respected patients' social and cultural needs and how this related to their care. Staff greeted patients politely upon their arrival and refreshments were offered whilst they waited for their clinic appointment.
- Patients' privacy and dignity was respected. Patients were cared for postoperatively behind curtains. Preoperative consultations, including and health assessments were always carried out in consultation rooms to maintain privacy.

Good

Surgery

- Patient satisfaction survey results from PHIN showed that 98% of patients felt their needs and all aspects of their care had been met.
- Prior to our inspection we provided comment cards. Patients said they were always treated very well and that the staff were polite and efficient.

Emotional support

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Staff communicated with patients in a way that they could understand their care and treatment. Information provided verbally was also given in writing in an easy to understand format.
- Patients were given time at the end of each visit to allow for questions they may have had.
- Relatives of patients who required additional support were encouraged to stay with the patient if the patient wished for them to stay. For example, staff told us if patients were anxious about their procedure, they would ask if they wanted a friend or relative to stay with them throughout their time at the clinic.
- Patients were advised at the booking stage of all possible costs that would be incurred. This was also available on the website, so that patients were fully aware of the cost implications of their treatment.

Understanding and involvement of patients and those close to them

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

Are surgery services responsive?

Good

Our rating of responsive improved. We rated it as **good.**

Service delivery to meet the needs of local people

- **The clinic planned and provided services in a way that met the needs of local people.**
- The clinic planned and delivered services in a way that met the needs of the local population. The importance of flexibility and choice was reflected within the practice of the clinic.
- The facilities and premises were appropriate for the services provided. There was a waiting area, four consultation rooms appointments, one theatre and one recovery room. This was sufficient for the number of patients seen.
- Evening and weekend consultation appointments were offered to patients to provide flexibility and choice. The clinic provided ad-hoc weekend theatre sessions in order to meet the needs of its clients.

Meeting people's individual needs

- **Patients' individual needs were taken account of.**
- All admissions were pre-planned so staff could assess patients' needs before their treatment. This allowed staff to plan patients' care to meet their specific requirements, for example physical needs.
- Pre-assessment was used effectively to ensure the unit only treated patients if they could meet their needs. The pre-assessment nurse confirmed that all patients were pre-assessed for surgery in advance.
- Staff told us that patients living with a learning disability or who had any other additional needs would be highlighted at the pre assessment stage. The purpose of this was to alert clinical staff to the patient's individual needs. This allowed staff to plan effectively, for example by arranging theatre lists in a way that lessened anxiety for particular patients. The clinic informed us that they had not been alerted to any patients with a learning disability.
- Reasonable adjustments had been made to ensure that disabled patients could access and use services on an equal basis to others. All areas of the service were wheelchair accessible. The clinic was situated on the ground floor and doors were the appropriate size to allow wheelchair access.

- We were told that discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation was avoided when making care and treatment decisions. However, during our inspection we did not see an equality and diversity policy. During our last inspection there was a not an exclusion / admission policy in place however we found that this was evident in the admission and discharge policy.
- Patients could be referred for psychiatric support if required. Staff told us the consultant would refer patients to their GP or a local NHS trust if they felt they required psychiatric support. However, there was no service level agreement in place.
- There was no hearing loop available in the clinic for patients who were hard of hearing.

Access and flow

- **People could access the clinic when they needed it.** Waiting times from treatment were and arrangements to admit, treat and discharge patients were in line with good practice
- Patients had timely access from initial consultation to procedure, and postoperative follow up appointments. From records we reviewed, we saw that most patients had their procedure within five weeks of their preoperative consultation. All patients were given a minimum of two weeks from consultation and procedure, to reflect on the information provided.
- On arrival at the clinic, patients booked in at reception, staff were informed when the patient had arrived. When the clinic staff were ready to admit the patient, they were collected from the reception and taken to a space within the recovery area. Pre- admission checks and assessments were undertaken, when completed the patient changed and waited for their procedure in the recovery room, curtains were drawn to ensure privacy and dignity were maintained. Staff then escorted patients to the theatre for their procedure. The majority of patients walked to theatre rather than going on a trolley or wheelchair. Immediately after surgery, staff cared for patients in the recovery room.
- Patients attended their procedures at staggered times, which meant that they did not have to wait for long periods of time and received more individual care.
- An appointments system was in use. Patients did not wait long for initial consultations, due to the flexibility of consultants and clinic opening hours. There were up to four theatre lists per week dependent upon patient activity. Saturday operating lists were offered to patients who preferred to be operated on during the weekends.
- Waiting times were not formally monitored due to the size of the clinic and small patient numbers.
- Clinic staff reviewed operating lists in advance. This ensured there was sufficient time to arrange all the necessary staff and equipment to ensure appointments were not delayed or cancelled.

Learning from complaints and concerns

- **Concerns and complaints were treated seriously, investigated and lessons learned from the results, which were shared with all staff.**
- Information on how to make a complaint was detailed in customer complaints procedure, which was displayed in the reception waiting area. This explained the process for making a complaint, including contact details and timescales.
- Staff were knowledgeable about the complaints process and were able to explain what they would do if a patient complained. There was a customer complaints standard operating procedure in place dated October 2017, this was due to be reviewed in September 2018, but this had not been completed prior to our arrival. The policy stated that staff must attempt to resolve all issues informally on initial receipt of a complaint.
- The clinic manager told us that they were responsible for managing complaints. There had been no complaints from October 2017 to November 2018.However, unresolved verbal complaints and written complaints were acknowledged by the registered manager within 48 hours. All complaints were investigated and responded to within 20 days.
- As there had been no complaints at the time of our inspection, we saw no evidence of complaints being discussed. However, we saw evidence that complaints were a standing agenda item at staff and governance meetings. We also saw evidence of patient feedback and comments being discussed and acted upon at staff meetings.
- There had been no complaints referred to onto the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) in this period.

Are surgery services well-led?

Good

Surgery

Good

Our rating of well-led improved. We rated it as **good.**

Leadership

Leaders within the clinic had the skills, knowledge and experience required to run a service providing sustainable care.

- The Stratford Clinic formed the healthcare division of SWFT Clinical Services Ltd, other divisions included pharmacy and property. The senior corporate management team for the wider company was based off-site. The team consisted of the company chair, a managing director, a medical director, a quality governance manager, and the registered manager. The clinic was managed by the registered manager.
- There were clear lines of responsibility and accountability within the team, which were easily identified by staff.
- The clinic manager led the service for the health care division of SWFT Clinical Services Ltd. The clinic manager was based on site which ensured visibility within the clinic. Staff we spoke with said they felt very supported by the clinic manager and were reassured by her clinical knowledge and approachability.
- On our previous inspection we could not be assured that the senior management team had taken appropriate action to ensure care and treatment was delivered according to national standards. However, on this inspection we saw that all national standards relating to clinical aspects of the clinic had been addressed and maintained such as appropriate procedures for dirty instrumentation, storage and administration of controlled drugs and access to required emergency medicines.
- The clinic manager ensured that staff were involved in the development of local standard operating procedures. Operating procedures explain how procedures and processes were completed in line with national and clinical guidance to provide safe practice. For example, the team recently updated the clinic's conscious anaesthetic procedure ensuring all required guidance from the AfPP was followed.
- Staff told us that the clinic manager actively involved the whole team in their ongoing professional development. The clinic manager was responsible for ensuring that revalidation was completed in line with the nursing and midwifery council requirements.

Vision and strategy

- **The clinic did not have a vision for what it wanted to achieve.**
- On our previous inspection there was no formal vision, strategy or values in place. During this inspection the managing director and clinic manager explained that due to financial constraints on the business, SWFT Clinical Services Ltd, was considering other viable options in relation to their healthcare division. Therefore, they were unable to provide a robust vision and strategy for the clinic at the time of our inspection. Staff were aware that the clinic was restructuring and that there would be some changes.
- The clinic was unable to standardise formal agreements with the medical consultants to attend any governance meetings as they had not signed a contract with SWFT clinical services. We were told that this was in progress and depended upon the clinic's future.

Culture

- **The clinic promoted a positive culture that supported and valued staff.**
- There was a culture of transparency and honesty amongst staff. Staff told us managers encouraged and supported them to report incidents. Staff we spoke with had not been involved in failings of care that would have led to responsibilities to implement duty of candour, but had an awareness of the policy and where to find it.
- Staff told us they enjoyed their jobs, were proud of the unit and of the treatment and care they provided to patients.
- Staff morale was good within the clinic. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience. The clinic manager operated an informal "open door" policy to facilitate communication with employees.
- Across all areas staff said they were committed and passionate about the care they provided to patients. They reported feeling proud to work within the clinic setting and were positive about the job they did.

- There was an emphasis on the safety and wellbeing of staff. The clinic manager had implemented a positivity board, where staff could express positive feelings. During our inspection we saw comments thanking each other for being a great team.
- Staff we spoke with felt that they were listened to by the clinic management and could openly raise concerns. All clinic staff felt they could raise concerns without any reprisal.
- We saw cooperative, supportive and appreciative relationships among staff groups. They worked collaboratively which meant staff were enabled work with and to meet the needs of patients within the clinic surrounding.

Governance

- **The quality of services were improved by creating an environment in which excellence in clinical care would develop.**
- Quality, performance, incidents and if there had been any complaints were discussed at monthly clinical governance meetings. The registered manager had developed a manager report which was included an update of these elements. This was tabled at each meeting to ensure attendees at the clinical governance meeting were aware of what was happening in the clinic.
- Following the 2017 staff satisfaction survey, a bi-monthly e-newsletter and company management quarterly team briefs had been introduced. This was chaired by the executive director to ensure effective communication was maintained and to give staff an opportunity to raise any concerns formally.
- On our previous inspection we saw that there were not robust processes in place for granting and renewing practising privileges. However, on this inspection we saw that all consultants who had been granted practising privileges had professional indemnity insurance in place and had provided their GMC (general medical council) number. The clinic manager informed us that the clinic was in consultation with the medical providers regarding a more robust accountability process.
- There was no process in place for checking staff employment records on the previous inspection, however on this inspection we found staff records to be updated with disclosure and barring service (DBS) certificates to be in date.
- There was a programme of internal audits used to monitor compliance such as hand hygiene, health and safety and patient pathways. Audits were completed monthly, quarterly or annually within the clinic depending on the audit schedule. Results were shared at relevant meetings, for example governance meetings.

Managing risks, issues and performance

- **There were systems in place to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- The risks that were described accurately reflected the concerns described by the clinic staff. The clinic manger and governance manager reviewed the risk register regularly and escalated issues to the board when necessary. Clear actions, mitigations, timescales for action, and risk owners were in place for the risks identified.
- There was an up to date risk register process in place. The risks related directly to the clinic and risks were discussed and updated at the risk, health and safety meetings. The highest rated risks were then reviewed at the clinical governance meetings. Staff were aware of the risks on the risk register despite there being no evidence that risks were reviewed at staff meetings.
- All risks were input on the electronic system by the governance team to ensure they had full oversight of them. Risks were owned by senior staff and the risks we reviewed were managed effectively. Risks were discussed and agreed at the divisional meetings before a risk was put on the register.
- The registered manager had oversight of all procedures undertaken in the clinic and observed procedures on an ad hoc basis to review practice.

Managing information

- The clinic collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. The clinic used paper records. Nursing and medical patient records were combined within the same record; this meant that all health care professionals could follow the patient pathway clearly.

- Results of x-rays and blood tests were available electronically, which all relevant staff could access. Patient discharge letters were printed and sent to the patient's GP. A copy was kept at the clinic and a third copy was given to the patient.

Engagement

- The clinic manager worked closely with the staff and met daily to have informal meetings. There were quarterly meetings with the board of director to cascade information from board meetings to the clinic staff.
- We saw noticeboards displaying information to inform staff on a variety of subjects for example health and safety and lessons learned from incidents and complaints.
- The clinic worked closely with the neighbouring local trust to ensure that all training and local policies were adhered to.

Learning, continuous improvement and innovation.

The clinic was committed to improving services. They mostly learned lessons when things went well or wrong promoting training and innovation.

- During our inspection, we found a number of matters that had improved since the previous inspection:

  - Mandatory training compliance had improved for safeguarding and resuscitation training.

  - Swab, needle and instrument counts were performed in line with national guidance.

  - Processes were in place that ensured instruments were decontaminated and sterilised appropriately.

  - An exclusion and admission criteria was in place.

  - Controlled drugs were stored in line with Controlled Drugs (Supervision, management and use) Regulations, DH 2013 and NICE guideline NG46.

  - Audits had been completed and patient outcomes monitored through PHIN.

  - Processes were in place to ensure consent processes were documented and completed in line with guidance.

- However, some policies seen on inspection had not been updated and did not reflect the clinics processes and services provided.
- The clinic manager was proud of the team, they said that the staff were really engaged and looked-for solutions rather than problems and demonstrated desire to make improvements.

Good

Outpatients

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

Are outpatients services safe?

Good

The main activity was surgery, so where outpatient services reflected what happened within surgery, we have not repeated it here.

Our rating of safe improved. We rated it as **good.**

Mandatory training

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

Safeguarding

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

Cleanliness, infection control and hygiene

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

Environment and equipment

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

Assessing and responding to patient risk

- Consultants were supported by a registered nurse when giving treatment to patients, for example intravitreal and joint injections.
- Nurses completed an intravitreal injection checklist. The checklist included which side the patient was having their injection, batch number, expiry date and ensured the consultant had checked the patient's details.
- Surgical patients who had their procedure performed elsewhere and only had their preoperative and postoperative appointments at the clinic, had all risk assessments completed where surgery had taken place.
- See further information under this sub-heading in the surgery section.

Nurse staffing

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

Medical staffing

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

Records

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

Medicines

- For our detailed findings on medicines please see the safe section in the main service report.

Incidents

Good

Outpatients

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

Safety Thermometer (or equivalent)

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

Are outpatients services effective?

Not sufficient evidence to rate

The effective key question is not rated in outpatients as there is insufficient evidence to do so.

Evidence-based care and treatment

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

Nutrition and hydration

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

Pain relief

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

Patient outcomes

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

Competent staff

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

Multidisciplinary working

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

Seven-day services

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

Health promotion

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

Consent and Mental Capacity Act (Deprivation of Liberty Safeguards only apply to patients receiving care in a hospital or a care home)

- For our detailed findings on consent, Mental Capacity Act and Deprivation of Liberty Safeguards, please see the effective section in the surgery report.

Are outpatients services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

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

Emotional support

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

Understanding and involvement of patients and those close to them

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

Good

Outpatients

Are outpatients services responsive?

Good

Our rating of responsive improved. We rated it as **good**

Service delivery to meet the needs of local people

- The environment was appropriate for the services delivered. There was adequate comfortable seating, toilets, a water machine and a hot drinks machine for patients and their relatives waiting for their outpatient appointment.
- Car parking was very limited. The clinic staff planned services to ensure there was not too many patients at the clinic at one time due to the limited parking facilities.
- See more detailed information under this sub-heading in the surgery section.

Meeting people's individual needs

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

Access and flow

- Patients were offered appointments on weekdays, weekends and evenings depending on the availability of the consultant they wished to see.
- For our detailed findings on access and flow, please see the responsive section in the surgery report.

Learning from complaints and concerns

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

Are outpatients services well-led?

Good

Our rating of well-led improved. We rated it as **good.**

Leadership

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

Vision and strategy

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

Culture

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

Governance

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

Managing risks, issues and performance

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

Managing information

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

Engagement

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

Learning, continuous improvement and innovation

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

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The clinic should ensure that the resuscitation trolley is tamper proof in line nationally recommended guidance.
- Medication should be administered and prescribed in accordance with national guidance.
- All policies should be in date and relevant to the clinic setting.
- Staff should ensure that evidence is present on equipment which identifies cleaning has taken place following each use.
- The clinic should ensure there is a robust vision and strategy.