CESP (Bristol) LLP - Bristol Eye Hospital

Quality Report

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

Ratings

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

Overall summary

South West Eye Surgeons LLP provides a range of specialist eye care for adults, children and young people at CESP (Bristol) LLP – Bristol Eye Hospital (the hospital). Services for children and young people made up 2% of the services provided in the reporting period, this has been included in the surgical core service report.

The service is currently registered with the CQC as CESP (Bristol) LLP – Bristol Eye Hospital but is in the process of changing its name. Work is undertaken under the provider parent name of South West Eye Surgeons LLP.

The service mainly provides private care to patients; however, they have an arrangement with the local clinical

Summary of findings

commissioning group to provide NHS patients treatment as part of a waiting list initiative. This accounts for 10% of their total patients in the reporting period of March 2016 to April 2017.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 3 July 2017, along with an unannounced visit to the hospital on 20 July 2017.

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

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

We rated this service as inadequate overall.

Safe and well led were rated as inadequate, effective was rated as requires improvement and caring and responsive were rated as good.

- There were limited systems and processes to provide oversight of the quality and safety of the services provided. The provider relied on the systems and processes of the hospital they carried out the surgical procedures in, but did not gain assurance from the hospital of this.
- There was limited use of systems to record and report safety concerns. Although there was an incident reporting system in place, staff were not aware of this and said they reported incidents using the hospitals reporting system rather than the provider's system. No incidents had been reported using the provider's reporting system and as such no investigations had taken place, learning identified or feedback provided to staff.
- Safeguarding was not given sufficient priority. There was no evidence of training undertaken by staff and systems were not clear, although staff knew how to report a safeguarding concern.
- Information about safety was not always comprehensive or timely. Safety concerns were not identified. There was no safety dashboard in place, no safety audits carried out, for example, on compliance with infection control practices, or the World Health Organisation surgical safety checklist. However, practice seen on inspection indicated good practice.
- The monitoring of the safety systems implemented at the hospital was not robust. Senior staff held monthly meetings but these were unrecorded. There was no environmental audit in place.The provider had no assurance that the maintenance of facilities, environment and equipment they used in the delivery of care was safe or if there were any risks posed to patients as a result of this.
- There was no oversight of the mandatory training or employment checks for the trained nurses and consultants that they employed or engaged under practising privileges. Although all staff employed worked within a local NHS trust and were known to the partners, there was no evidence of training undertaken by staff or evidence of employment checks being carried out.
- Medicines were not always prescribed prior to being administered to patients and there were no patient group directions in place to cover this.
- Records were not always maintained of medical photography.
- There was limited assurance that patients' care and treatment reflected current evidence based practice because the provider relied upon the hospital undertaking this work. There was no evidence that this was monitored by the provider.
- There was no evidence of how the provider and senior managers monitored and used current evidence based guidance, standards, best practice and legislation to develop the service.
- The outcomes of patient's care and treatment were not always monitored regularly. Participation in internal and external audits and benchmarking was limited. The service did not submit data to the Royal College of Surgeons, Patient Reported Outcome Measures (Q-PROMS) or the Private Healthcare Information Network (PHIN).

Summary of findings

- There was limited oversight that staff had the right training, only carried out surgery they were skilled for and had the correct employment checks.
- There was no evidence to show that staff received regular appraisal from the provider, or training and development opportunities.
- Patient concerns raised during the feedback survey were not clearly actioned. The executive committee meetings did not have complaints as a standard agenda item.
- There was limited awareness of the organisational vision and values.
- The arrangements for governance and performance management did not operate effectively. There was no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance at Bristol Eye Hospital.
- Quality did not receive sufficient coverage in executive meetings and was not documented in other relevant meetings. There was no evidence of performance monitoring or of assurance gained about the quality and safety of the service.
- Leaders did not have the necessary experience or support to lead effectively. Leaders were not always clear about their roles and their accountability for quality.
- The service level agreement between the provider and the local NHS trust was dated 2007 and was not monitored or reviewed regularly.

However, we found some good practice:

- Although staff were using the wrong reporting system, they said they felt able to report incidents and that there was a good reporting culture. Most staff understood their responsibilities under the duty of candour, although there was no evidence of the need to do so.
- Medicines were stored securely.
- We observed good hand hygiene practice in clinical areas and patients confirmed this.
- During the reporting period, there were no incidences of hospital-acquired infection.
- Patient records were secured, well maintained and clear to follow.
- We observed good compliance with the World Health Organisations (WHO) surgical safety checklist.
- There were sufficient staff on duty at the time of our inspection to meet patients' needs. There were also arrangements in place to ensure that children and young people were cared for by suitably qualified and experienced staff.
- Outcomes that were measured for ophthalmic surgery were good. Posterior rupture rates were below the national benchmark and as such were better than expected.
- There had been no unplanned transfers of care to other hospitals and no unplanned readmissions.
- Consultants and nursing staff understood the relevant consent and decision-making requirements of legislation and guidance. There was evidence that consent practices were in line with guidance and best practice.
- Patients were given the opportunity to take a period of reflection following a consent discussion and prior to surgery.
- Feedback from people who use the service, those who are close to them and stakeholders was positive about the way staff treated people.
- Patients were involved and encouraged to be partners in their care and in making decisions about their treatment and support.
- There were transparent and easy to understand pricing structures.
- Staff responded compassionately when patients needed help.
- Services were planned and delivered in a way that met the needs of the local population.
- Patients reported they had timely access to initial assessment, diagnosis and treatment. However, the provider did not monitor this.

Summary of findings

- Care and treatment was only cancelled when necessary. Only one patient had their procedure cancelled between April 2016 and March 2017 and they were offered another appointment within 28 days.
- There was equal access to people who were visually impaired and had physical disabilities.
- Information was provided pre-operatively on how to make a complaint or raise a concern.
- Patient information could be provided in large print and Braille format.
- There was clear communication between multidisciplinary teams and administrative staff and external partners.
- No complaints had been made to the service.
- The organisation actively sought the views of patients and staff about the quality of the service provided.

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

Amanda Stanford

Deputy Chief Inspector of Hospitals (hospitals directorate)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Inadequate** 	Surgery was the only activity provided at the hospital. Children and young people's services were a small proportion of hospital activity and we have included findings in the surgery core service. We rated the safety, and well-led domains of this service as inadequate and the effectiveness of the service as requires improvement. We rated the responsiveness and caring domains of this service as good.

Summary of findings

Contents

Inadequate

CESP (Bristol) LLP - Bristol Eye Hospital

Services we looked at
Surgery

Summary of this inspection

Background to CESP (Bristol) LLP - Bristol Eye Hospital

South West Eye Surgeons Partnership LLP operate a private specialist eye service from CESP (Bristol) LLP - Bristol Eye Hospital. The private practice based in Bristol opened in 2003 and primarily serves the communities of Bristol and the South West.

The service provides care and treatment to private patients and also to NHS patients through a contract with the clinical commissioning group.

The service provides ophthalmology procedures, including cataract and laser surgery, as well as minor cosmetic eyelid and brow procedures.

CESP (Bristol) LLP – Bristol Eye Hospital are registered with the Care Quality Commission to deliver the following regulated activities,

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

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

CESP (Bristol) LLP – Bristol Eye Hospital had previously been inspected in 2013 and 2014 when all standards had been met.

Our inspection team

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

Information about CESP (Bristol) LLP - Bristol Eye Hospital

Consultants and nursing staff who work at the CESP (Bristol) LLP – Bristol Eye Hospital (the hospital) provided specialist eye services to private and NHS patients from the South West. All staff worked for the NHS and outside of these hours, had a separate contract with the hospital. The provider (South West Eye Surgeons LLP) had an agreement with the hospital to use their surgical facilities when not in use by the NHS. Theatre lists, ran from 5pm to 8pm on Monday to Friday and some on Saturdays.

During the reporting period, April 2016 to March 2017 patients as part of an NHS waiting list initiative made up 10% of the patient caseload. Patients were seen pre- and post-operatively at the outpatient facility.

Ninety percent of care was delivered on the day-case unit at the hospital, if a patient required an overnight stay they were cared for on Gloucester ward (a ward in the hospital). Children were cared for in a designated area on Gloucester ward, if an overnight stay was required they would be transferred to the children's hospital.

During the inspection, we visited the day case unit, theatres, theatre recovery, Gloucester ward and the segregated children's area on Gloucester ward.

We spoke with 14 members of staff including; registered nurses, technicians, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with six patients and one relative and reviewed eleven sets of patient records.

There were no special reviews or investigations of CESP (Bristol) LLP ongoing by the CQC at any time during the 12 months before this inspection. The service had previously

Summary of this inspection

been inspected twice, the most recent inspection took place in February 2014, which found that the service had met all standards of quality and safety it was inspected against.

Activity

- In the reporting period April 2016 to March 2017 there were 281 operations carried out, only 11of these patients occupied an inpatient bed overnight.
- Most surgery was carried out using local anaesthesia, but 20 procedures were carried out using a general anaesthetic.
- Ten percent of the 281 operations carried out were on NHS patients.
- Two percent (five) of the operations carried out were delivered to children aged from three to 15 years of age at the children's eye hospital under the care of a specialist eye surgeon and paediatric nurses.

Ten surgeons worked for CESP (Bristol) LLP – Bristol Eye Hospital under practicing privileges. The provider employed hospital nursing staff under an agreement with the hospital. All staff were paid by the provider directly.

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

Services provided at the hospital under the 2007 service level agreement:

- All equipment for the purpose of providing medical eye care
- Theatre suite
- Consulting rooms
- Waiting areas
- Reception areas
- Meeting rooms

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- There was limited use of systems to record and report safety concerns. Staff told us there was a good culture of incident reporting, however staff said they reported incidents using the hospitals system rather than the provider's system. No incidents had been reported using the provider's reporting system and as such no investigations had taken place, learning identified or feedback provided to staff.
- Safeguarding was not given sufficient priority. There was no evidence of training undertaken by staff and systems were not clear, although staff knew how to report a safeguarding concern.
- Information about safety was not always comprehensive or timely and safety concerns were not always identified. There was no safety dashboard in place, no safety audits carried out, for example, on compliance with infection control practices, or the World Health Organisation surgical safety checklist. However, we observed these activities during the inspection and saw evidence of good practice.
- The monitoring of the safety systems implemented at the hospital was not robust. Senior staff held monthly meetings but these were unrecorded. There was no environmental audit in place.The provider had no assurance that the maintenance of facilities, environment and equipment they used in the delivery of care was safe or if there were any risks posed to patients as a result of this.
- There was not full oversight of the mandatory training or employment checks for the trained nurses and consultants that they employed or engaged under practising privileges. Although all staff employed worked within a local NHS trust and were known to the partners, there was no evidence of training undertaken by staff or evidence of employment checks being carried out.
- Medicines were not always prescribed prior to being administered to patients and there were no patient group directions in place to cover this.
- Records were not always maintained of medical photography.

However:

Summary of this inspection

- Staff said they felt able to report incidents and that there was a good reporting culture. Most staff understood their responsibilities under the duty of candour, although there was no evidence of the need to do so.
- We observed good hand hygiene practice in clinical areas and patients confirmed this.
- During the reporting period, there were no incidences of hospital-acquired infection.
- Medicines were stored securely.
- Patient records were secured, well maintained and clear to follow.
- We observed good compliance with the World Health Organisations (WHO) surgical safety checklist.
- There were sufficient staff on duty at the time of our inspection to meet patients' needs. There were also arrangements in place to ensure that children and young people were cared for by suitably qualified and experienced staff.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- There was limited assurance that patients' care and treatment reflected current evidence based practice because the provider relied upon the hospital undertaking this work. There was no evidence that this was monitored by the provider.
- There was no evidence of how the provider and senior managers monitored and used current evidence based guidance, standards, best practice and legislation to develop the service.
- The outcomes of people's care and treatment was not always monitored regularly. Participation in internal and external audits and benchmarking was limited. The service did not submit data to the Royal College of Surgeons, Patient Reported Outcome Measures (Q-PROMS) or the Private Healthcare Information Network (PHIN).
- There was limited oversight that staff had the right training, only carried out surgery they were skilled for and had the correct employment checks.
- There was no evidence to show that staff received regular appraisal from the provider, or training and development opportunities.

However:

- Outcomes for ophthalmic surgery were good. Posterior rupture rates were below the national benchmark and as such were better than expected.

Summary of this inspection

- There had been no unplanned transfers of care to other hospitals and no unplanned readmissions.
- Consultants and nursing staff understood the relevant consent and decision-making requirements of legislation and guidance. There was evidence that consent practices were in line with guidance and best practice.
- Patients were given the opportunity to take a period of reflection following a consent discussion and prior to surgery.

Are services caring?

Good

We rated caring as good because:

- Feedback from people who use the service, those who are close to them and stakeholders was positive about the way staff treated people.
- Patients were involved and encouraged to be partners in their care and in making decisions about their treatment and support.
- There were transparent and easy to understand pricing structures.
- Staff responded compassionately when patients needed help.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned and delivered in a way that met the needs of the local population.
- Patients reported they had timely access to initial assessment, diagnosis and treatment. However, the provider did not monitor this.
- Care and treatment was only cancelled when necessary. Only one patient had their procedure cancelled between April 2016 and March 2017 and they were offered another appointment within 28 days.
- There was equal access to people who were visually impaired and had physical disabilities.
- Information was provided pre-operatively on how to make a complaint or raise a concern.
- Patient information could be provided in large print and Braille format.
- There was clear communication between multidisciplinary teams and administrative staff and external partners.
- No complaints had been made to the service.

However:

- There was limited monitoring of performance.

Summary of this inspection

- Patient concerns raised during the feedback survey were not clearly actioned. The executive committee meetings did not have complaints as a standard agenda item.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- There was limited awareness of the organisational vision and values.
- The arrangements for governance and performance management did not operate effectively. There was no recent review of the governance arrangements, the strategy, plans or the information used to monitor performance at Bristol Eye Hospital.
- Quality did not receive sufficient coverage in executive meetings and was not documented in other relevant meetings. There was no evidence of performance monitoring or of assurance gained about the quality and safety of the service.
- Leaders did not have the necessary experience or support to lead effectively. Leaders were not always clear about their roles and their accountability for quality.
- The service level agreement between the provider and the local NHS trust was dated 2007 and was not monitored or reviewed regularly.

However:

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

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Inadequate

Surgery

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

Are surgery services safe?

Inadequate

We rated safe as inadequate because:

Incidents

- Staff told us there was a good culture of incident reporting. Staff in theatres and on the day case unit, told us of their responsibility, and felt supported to report incidents. The provider had an incident reporting system in place but staff were not aware of this and said they reported incidents via the hospitals reporting system. There was no evidence that any clinical incidents had been reported and as a result, no feedback or learning had been identified.
- The incident reporting policy consisted of three lines, was unclear and did not provide guidance of which system to use.
- There were no never events, serious incidents or incidents reported in the 12 months prior to our inspection for patients who were cared for at the hospital. 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.
- There was no evidence that when something went wrong, an investigation, or review was carried out. There was no evidence that patients or their families received an apology when things went wrong, or that learning was identified and shared.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.
- Some staff understood their responsibilities to patients. However, not all staff could give an example of when this had happened and when questioned showed a limited understanding of the regulation.

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

- There was no quality dashboard maintained by the provider for care and treatment provided at the hospital. Managers within the service did not have oversight of a quality dashboard and no audit was carried out to ensure the safety of the service.

Cleanliness, infection control and hygiene

- There were systems in place to prevent and protect patients from healthcare-associated infections. The provider had an infection control policy in place. However, there were no systems in place to audit compliance against this.
- Arrangements were in place for the safe disposal of clinical waste to prevent accidental injury or cross contamination. The day case unit, ward and theatres had properly assembled clinical waste bins, which were labelled correctly and filled below the recommended level.

- During the reporting period, between April 2016 and March 2015, there were no incidences of hospital-acquired methicillin-resistant Staphylococcus aureus (MRSA), methicillin-sensitive Staphylococcus aureus (MSSA), Escherichia coli (E-Coli) or Clostridium difficile.
- Staff on the day case unit decontaminated their hands in line with the World Health Organisations five moments for hand hygiene and NICE guidance (QS 61 statement three). This standard states that people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. All the patients that we spoke with told us that they saw staff decontaminate their hands before and after patient contact.
- The areas we inspected were all visibly clean and free from dust. Cleaning of the environment was provided by the hospital. Records of cleaning schedules showed that there were occasions where the theatres, recovery and anaesthetic rooms had not been signed to confirm that cleaning had been completed. There was no evidence that this had been followed up by the provider with the hospital.Staff at the hospital
- showed us how they kept the equipment clean by completing daily cleaning and attaching a green ticket. Any ward equipment which was stored in the corridors had stickers indicating it was cleaned within 24 hours.

Environment and equipment

- The provider had no assurance about the maintenance of the facilities, environment and equipment they used in the delivery of care. There were no recorded regular meetings with the hospital, no records nor reports which provided them with this assurance.
- There was no evidence that the provider had carried out any assessments of risk relating to the building environment or equipment themselves or in conjunction with the hospital, since they started using the facilities.
- We asked the provider if they had an overall understanding and oversight of any standard operating procedures to gain assurance that equipment was being used safely and in line with manufacturers guidance. We were told that they did not as these were held by the hospital. They relied upon communications between the theatre manager (from hospital) and the registered manager at monthly meetings when any risks to services were identified and discussed. However, these meetings were not documented.
- There were policies and procedures, which highlighted the responsibilities to undertake regular review and audit of the building, environment and equipment. This document stated, that: “the manager will also conduct an annual audit on each site to determine compliance with risk management, health and safety legislation and ensure that appropriate measures are in place.” There was no evidence that this had been carried out and there was no oversight that the space they rented was safe.
- We observed that clinical waste was removed safely from theatres, and was not transported through clean areas. All waste was moved into a designated corridor for removal and then transported to the main clinical waste store.
- We saw that anaesthetic equipment was checked in line with The Association of Anaesthetists of Great Britain and Ireland. We checked two months of records in two theatres and all checks were fully completed, signed and dated.
- We checked six pieces of medical equipment and saw that all had in date electrical safety checks and expiry dates.
- The resuscitation equipment in the day case unit was sealed with a tamper proof seal. The trolley was checked monthly unless it was opened where it was checked immediately after use. All checks were signed and dated and any actions, expired pieces of equipment were documented as replaced.
- The provider did not keep their own record of the specific implants and equipment used in order that they could provide information rapidly to the healthcare products regulator. However, this was maintained in the same record as that for the hospital and the information was accessible via the theatre manager.

Inadequate

Surgery

Medicines

- The provider used the hospital policy on safe use of medicines. Staff told us that they acted in accordance with these policies and follow requirements and guidance. We observed staff acting in accordance with good practice during our inspection.
- All medicines at the hospital not requiring refrigeration were stored in locked cupboards and pharmacy stores were kept in a locked room with a keypad entry.
- Medicines requiring refrigeration were stored in a locked refrigerator in a lockable treatment room and in the anaesthetic rooms. Refrigerators were checked daily to ensure that they were in the recommended range. The readings were kept for inspection. We checked three fridges during the inspection period we found one fridge in theatre one had only nine out of 19 daily checks completed. If readings were taken outside this range, staff told us that the theatre manager or nurse in charge would be informed immediately.
- Of the six sets of patients records reviewed, we found that prescriptions for eye drops had not been signed by a doctor but had been ticked on the care pathway as administered by a nurse practitioner. We confirmed with the hospital that the nurse practitioner was not approved as a nurse prescriber.
- There were no patient group directions in place to enable nurses to administer medication without a prescription.

Records

- Patients' records were, organised and easy to follow, written legibly signed by the consultant and contained clinic letters, communications with patients and referral letters. Electronic records of all communications with patients were held locally on a central server and all copies of communications were held in the patient's notes.
- We reviewed five sets of notes for patients who had minor cosmetic surgery. We found each set of notes had documented that pre-operative photographs should be taken and patients had signed consent for medical photography in line with CESP (Bristol) LLP – Bristol Eye Hospital policy. However, only one set of notes had a photograph stored within it. This was not in line with the General Medical Council guidance on making and using visual and audio recordings of patients, March 2013. We were informed post inspection that all photographs were downloaded on site, however not all photographs were kept in the patient record.

Safeguarding

- There was a safeguarding adults policy in place, but this did not provide details of who to report safeguarding concerns to or the telephone numbers to call. However, staff told us what processes they would go through if they needed to make a referral to the local safeguarding authority.
- There was a policy for safeguarding children, but this was not pertinent to the care and treatment provided as it indicated that no children would be treated by the service.
- During the reporting period of April 2016 to March 2017, 2% of patients treated were children. All children were cared for pre- and post-operatively on Gloucester Ward (a ward run by the hospital), where there was a separate paediatric bay for children. The provider ensured that operations on children were carried out on the days when other children were being operated on by the hospital to ensure a registered nurse (child branch) was available. This nurse was employed by the hospital and not by the provider. Operations were carried out in the morning for children rather than the evening to allow recovery time. There were no clear arrangements for this in place with the hospital.
- There were limited monitoring arrangements for the completion of safeguarding adults training and safeguarding children training for staff engaged under practising privileges. Senior staff told us that all consultants received training on the protection of children and young adults through their NHS training programme and the in date appraisal was proof enough of this. As they did not keep their own records they could not be sure safeguarding training was in date for all consultants and nursing staff.
- The provider kept a staff file on all the nursing staff who they employed. However, no information about safeguarding training (either for adults or children) was kept in these files. An agreement had been signed in 2007, which outlined theatre staff competence and compliance and assured that all staff underwent

mandatory training in accordance with hospital policies and procedures. However, this agreement had no end or review date and so no changes to working practices had been taken in to account.

Mandatory training

- The provider had no oversight that the consultants and nursing staff employed by them to deliver safe care and treatment at the hospital had received effective mandatory training.
- None of the nursing staff files had evidence of any completed mandatory training, for example, infection control or basic life support. One out of ten consultant files had evidence of mandatory training. We asked how the service was assured staff had received training and were told that this was covered in the 2007 written agreement for nursing staff and for all consultants covered in their appraisal carried out by their employing trust. This 2007 agreement had no review or expiry date therefore had not been updated with any changes to working practices.

Assessing and responding to patient risk

- We observed how staff working for the hospital assessed and responded to risks by completing the World Health Organisations (WHO) surgical safety checklist. The National Patient Safety Agency (NPSA) issued a patient safety alert recommending that all providers of surgical care use the WHO surgical safety checklist. This was incorporated into the five steps to safer surgery, which included pre-list briefings, the steps of the WHO surgical safety checklist and post-list debriefings in one framework. The checklist focused the whole team on the safety of practices before, during and after a procedure. We observed how staff carried out the WHO surgical safety checklist and saw all team members fully engage with the process. We reviewed 11 sets of patient notes all of which contained signed and fully completed checklists. However, the overall compliance in completing this safety standard was not audited and no observational audits of compliance with the WHO surgical safety checklist or five steps to safer surgery were completed.
- When patients were discharged, they were given a telephone number to contact an outsourced personal assistant service. This was in line with national guidelines for day case surgery. Patients could call this number with any out-of-hours concerns. The service would contact the registered manager who in turn would contact the consultant responsible. In cases where the condition was unsuitable to be dealt with at the provider's outpatient service, patients would be advised to attend either an NHS emergency department. We discussed the out of hours arrangements with three patients who had completed their surgery and all told us that the consultants had given them their own private mobile phone number should any issues arise. The patients told us they liked this and felt that it added a personal touch to the service. There were no records or audits of the number of out of hours contact that were made.
- CESP (Bristol) LLP – Bristol Eye Hospital used a surgical pathway that encompassed pre-, peri- and post-operative care. This pathway enabled staff to undertake patient risk assessments, record them and respond to them. We saw evidence of how staff assessed mobility and what actions they would take should they have concerns regarding patient's stability. However the service did not have an exclusion criteria policy to refer to should they need further advice.
- There were regular observations of patients taken prior to and during surgery, however, these were not part of an early warning scoring system to identify deterioration in a patient's general health.
- There was no service level agreement with the hospital to transfer a patient whose condition had deteriorated.
- Staff were aware of how to contact the consultants should they need advice abouta patient's medical condition, when they were not on site. There were clear details in each patient's notes.

Nursing and support staffing

- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times. The registered manager and theatre manager discussed the staffing requirement for planned surgery lists. There was no evidence that a particular staffing tool was used and there were no records or rotas in place. Senior staff at the hospital relied on the theatre manager to coordinate staffing for the day case unit and theatres. Staff employed by the provider worked for the NHS at the hospital during the day as their main place of work.

- The provider did not employ bank or agency nurses as there had never been an issue with a lack of staffing. Staff could request to work shifts once theatre lists were known and the theatre manager was responsible for ensuring adequate staffing levels. The registered manager and the theatre manager discussed any issues relating to staffing at the undocumented monthly meeting.

Medical staffing

- Six eye specialist partners and four associate partners delivered all the care and treatment to patients at the hospital under practicing privileges. All were consultants.
- There was 24-hour access to a consultant for the immediate postoperative period, either via an outsourced personal assistant company, or directly with consultants. If a patient should need to contact someone in an emergency and the situation could not be dealt with at the local private clinic then patients would be advised to attend the local emergency eye hospital department as an NHS patient.
- The provider did not keep copies of references, specific safety checks such as Disclosure and Barring Service checks or registration with the General Medical Council (GMC). All consultants held substantive posts at the local NHS trust (hospital). The provider relied upon the hospital to carry out appraisals and checks for consultants, but there was no record of any assurance gained. No further proof other than a completed signed appraisal was required for consultants to practice privately for CESP (Bristol) LLP – Bristol Eye Hospital. The service did not have oversight of any of its consultants safety checks, references or GMC registration.
- The service did not employ Registered Medical Officers or agency staff.

Emergency awareness and training

- The provider relied upon the hospitals business continuity plans for seasonal fluctuations, and the impact of adverse weather and disruption to staff.
- The provider had a building operational status checklist which detailed that fire alarms and detection systems were fully operational in 2007. There was no review date or further assurances that checks had been repeated as the provider relied on the hospital to carry these out.

Are surgery services effective?

Requires improvement

We rated effective as requires improvement because:

Evidence-based care and treatment

- The provider relied upon the hospital to ensure that care and treatment reflected current evidence-based guidance, standards and best practice. There was no evidence that this monitored within CESP (Bristol) LLP.
- Senior staff told us that requests from partners to undertake new clinical procedures, alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA), incidents, complaints, Royal College of Surgeons and National Institute for Health and Care Excellence (NICE) guidelines were discussed at their internal executive meetings. We reviewed eight sets of internal executive meeting minutes and could see no record of these topics discussed and none were included as itemised topics on the agenda.

Pain relief

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

Nutrition and hydration

- All patients were offered tea or coffee and a biscuit during their recovery from any procedure undertaken under local anaesthetic.
- Those patients undergoing general anaesthetic received nutrition in line with hospital policy, as stated in South West Eye Surgeons nutritional needs policy. The

provider did not provide a copy of this policy to us and it was not clear whether patients were provided information about when they needed to stop eating prior to surgery.

Patient outcomes

- Information about the outcome of patients care and treatment was not always collected and monitored. CESP (Bristol) LLP – Bristol Eye Hospital kept a spreadsheet of surgical outcomes, this included pre- and post-operative visual acuity, refraction and complications. CESP (Bristol) LLP – Bristol Eye Hospital compared their expected refractive outcomes, visual acuity outcomes and posterior capsular rupture rates against the National Ophthalmic Dataset (NOD). During the reporting period from April 2016 to March 2017 CESP (Bristol) LLP – Bristol Eye Hospital had no posterior rupture rates, which was better than the national benchmark of 2%. However, when we reviewed the spreadsheet data was missing which did not present a full picture. The provider told us that any deviation in an upward direction from two per-cent would be highlighted and investigated during their internal executive meeting.
- Minor eyelid and brow (blepharoplasty) cosmetic surgery was carried out and the provider was in the process of registering with the Private Healthcare Information Network (PHIN) at the time of the inspection to record the outcomes for the minor eyelid and brow (blepharoplasty) cosmetic surgery carried out. This independent, not for profit network helps patients make informed decisions about which care provider to access, the aim is to make sure all patients have access to trustworthy, comprehensive information on quality and price. All providers of private independent care in the UK were required by law to submit data to PHIN by February 2017.
- The hospital did not submit data to the Royal College of Surgeons, Patient Reported Outcome Measures (Q-PROMS) for blepharoplasties. This is a self-assessment of the patients' quality of life and how this was changed by surgical intervention.
- During the reporting period of April 2016 to March 2017 there had been no unplanned transfers of care to other hospitals and no unplanned readmissions.

Competent staff

- Patients who were admitted to the theatre lounge received care from a dedicated theatre lounge nurse. This nurse employed for that shift was responsible for managing a patient's admission, treatment and discharge.
- There were no appraisals carried out by the provider, staff told us that their appraisals were up to date and carried out by their NHS employer.
- There were no learning and development opportunities provided to staff by the provider.
- There was no documented scope of practice for consultants working at the hospital. There was no record if staff had the right training and only carried out surgery they were skilled for and were safe to practice. There was no assurance that procedures in specialist areas were being performed, monitored or discussed at the weekly internal executive meetings.
- There were no arrangements in place for granting and reviewing practising privileges and employment checks. Senior staff told us that they only employed current practising NHS substantive consultants from the local NHS trust. The provider took that as assurance that the consultants were safe to practice.
- The service did not follow their human resources policy which stated that "job descriptions, training, advertising for staff, annual appraisal, interview, bullying and harassment, practicing privileges and disciplinary issues are all up to date and issued to all staff. For this reason, strict employment policies are followed in ensuring that the employees are professionally qualified and fit for purpose to conduct their duties." We checked 10 consultant files. All had a copy of the up to date appraisal from the consultant's substantive post. However, we found only one contained a Disclosure and Barring Service (DBS) check. Nine out of the ten files had a signed declaration statement by the consultant to say they had a DBS from their substantive NHS post but no evidence existed. We brought this to the attention of the provider who took urgent action to ensure that DBS checks had been obtained for all staff.
- The content of all staff files lacked consistency, General Medical Council fee confirmation to show membership were out of date, confidentiality agreements were not

always signed or reviewed on the dates set. Evidence of mandatory training was inconsistent; out of 10 sets of files that we reviewed only three had evidence of training undertaken. The provider's human resources policy set out what pre-employment checks and evidence would be required prior to a consultant surgeon joining the partnership. The policy stated that two references were required, out of the ten files we checked we found only two sets contained references. Files for nursing staff employed lacked content. Files did not contain references, DBS checks, curriculum vitae or completed mandatory training. Senior staff told us that as the staff worked in the NHS this was enough assurance they were up to date with all of their training and checks.

Multidisciplinary working

- When necessary, staff worked together to assess and plan a patient's ongoing care. Staff told us that if a patient had difficulty administering drops they would be referred to external services through the hospitals online system or switchboard. Staff could not give an example of this happening as their patients only had minor, ambulatory day surgery.
- When a patient required an overnight stay, they could access a bed on Gloucester ward and be cared for by staff employed by the hospital. We were told this was part of the 2007 service level agreement. However, in the service level agreement, the facilities description did not include access to inpatient beds.

Access to information

- Staff told us that they had all the information they needed to deliver effective care and treatment. Private patients had their own separate sets of notes, which were delivered prior to their operation.
- Discharge letters were posted to GPs within two working days, the secretaries told us that it was important to update GPs of any long-term medication change.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consultants and nursing staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act, 2005. Staff we spoke with had completed training under their NHS employment and were confident in the application of the Mental Capacity Act 2005. The provider did not hold any evidence to support this and therefore could not be assured of staff competence with the Mental Capacity Act 2005.
- We reviewed the records of ten patients and looked at the consent forms for all of them. Consent was clearly documented for all of the patients and was in line with GMC guidance.
- The service provided minor cosmetic surgery to the eyelids and eyebrows and we reviewed five sets of notes for patients undergoing this treatment. Informed discussions were held prior to a patient signing the consent form and in advance of the scheduled operation day. This was in line with the provider's policy of an adequate period for reflection and consideration and Recommendation 20 of the Review of the Regulation of Cosmetic Interventions. All consent forms were signed and dated by the patient and the consultant.

Are surgery services caring?

Good

We rated caring as good because:

Compassionate care

- Feedback about the way staff treated people who used the service, those who were close to them and stakeholders was positive. People were treated with, respect and kindness during all interactions with staff and relationships with staff were positive. We spoke with six patients and one relative and they told us they felt supported and well cared for.
- We observed good interaction between the theatre team and patients who were nervous about their procedure. Every step was explained to the patient who was included with all the conversations that went on in the operating theatre. Patients were asked to complete a patient satisfaction survey. Views from patients about their admission, stay in hospital and their discharge were included. The satisfaction survey also asked if the

patient would refer the service to a friend or relative. The inpatient survey results showed how this related to the patient experience with 98% of patients recommending the consultant and the service.

- Healthcare professionals introduced themselves to the patients in their care. Nursing staff explained their roles and responsibilities when they met patients for the first time and continued to do so throughout their procedure.
- Patient's privacy and confidentiality was respected at all times. The provider recognised that this was a challenge as the patients only had one waiting room. We observed how staff took patients into a quiet area to discuss anything private.

Understanding and involvement of patients and those close to them

- People were involved and encouraged to be partners in their care and in making decisions about their treatment and support. Staff spent time talking to patients and their relatives. We saw how patients and their relatives received information about eye drops in a way that they could understand. Staff recognised the important role that relatives had post-operatively and included relatives, where necessary and agreed with the patient in discussions about the patient's care.
- There were transparent pricing structures. The patient guide stated all surgical procedures were quoted as an 'inclusive fee'. This meant the price included charges for the surgeon, anaesthetist, hospital fees and charges for follow up consultation.
- The service implemented the objectives of The Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients. Every patient we spoke with knew the name of their consultant, anaesthetist and nurse co-ordinating their care.

Emotional support

- Staff responded compassionately when people needed help. We observed how people were supported to meet their basic personal needs as and when required.
- We observed staff support a patient who was anxious prior to surgery with understanding, helping to put the patient at ease and calm their anxiety.

Are surgery services responsive?

Good

We rated responsive as requires good because:

Service planning and delivery to meet the needs of local people

- Services were planned and delivered in a way that met the needs of the local population. The provider was commissioned to provide care to NHS patients who were on an NHS waiting list. Stakeholders we spoke with told us that the service had been responsive to service provision by having flexible operating lists on Saturdays.
- There was no system in place to review the facilities and premises to ensure that they were appropriate for the services that are planned and delivered by the provider.
- There was no evidence that the provider identified where patients' needs were not met and as such, they did not use this to inform how the service was planned and developed.

Access and flow

- Patients had timely access to initial assessment, diagnosis and treatment. Referrals for consultations came from the GP or patients could self-refer. Appointments could be booked within three weeks. We spoke with the secretarial/booking staff who told us they aimed to provide patients with an initial appointment within two weeks. If patients needed to they could be seen for pre-assessment or follow up appointments at the outpatient clinic as well as at the hospital.
- Senior staff told us they did not audit waiting times, as they did not have waiting lists. However, we spoke with four patients who told us that the service had been quick, efficient and responsive. One patient told us they had they had received an appointment within three weeks and one patient managed to fit an appointment in around their holiday.
- If a patient required emergency treatment such as a return to theatre the consultant could be contacted either by the registered manager or directly from the

patient. This had not occurred during the reporting period. If a situation was deemed a medical emergency, the patient was told to attend an NHS accident and emergency department.

- Care and treatment was only cancelled when necessary. During the reporting period of April 2016 to March 2017 one patient had been cancelled for non-clinical reasons. The patient had been offered another appointment within 28 days.

Meeting people's individual needs

- The service provided equal access for people with physical disabilities. Staff were experienced in caring for patients who were visually impaired.
- The pathway used by the service stated that when necessary staff should consider contacting a translator. We asked staff how this was achieved and they told us that any translation services were pre-booked through the hospital secretaries. They had not had need to do this at the time of our inspection.
- The provider had developed their own patient information leaflets for a range of treatment and conditions. Options for large print and braille were offered and the emergency 24-hour phone number was clearly displayed.
- Staff made sure that patients had arrangements for when they were discharged from hospital. Booking staff at the outpatient clinic made sure prior to admission, that patients started planning who would take them home and, if required, administer eye drops.
- Staff told us if they had concerns about a patient who was unable to administer post-operative drops themselves they would be referred to the external services. We were told this was a rare occurrence as patients generally had minor, ambulatory day surgery.
- Staff at the booking office and staff at the hospital made sure that people who used the services were able to find out further information. We saw staff giving out leaflets with advice following eye surgery, such as how to administer eye drops and contact numbers in case of problems.
- Special attention was given to assessing whether the patient was able to administer treatment such as eye drops on their return home. We observed a patient being admitted, receiving their pre-operative eye drops and being discharged safely by the lounge nurse.
- The patient satisfaction survey results showed that patients rated the quality of the food poorly. Of people surveyed 43% and 35% approved of the choice of snack. We did not see any evidence of discussions of this in internal executive meetings minutes.
- Secretarial staff told us they liaised with the hospital in advance if they knew a patient was due to be admitted who lived with dementia, a learning disability, or with mental health problems in order that arrangements could be made to meet their needs. These included ensuring the support of relatives during the admission as well as identifying any additional support for individual needs. When necessary, the hospital staff made onward referrals for internal or external services for patients with additional needs, such as occupational therapy or district nursing.

Learning from complaints and concerns

- Clear information was provided for patients should they want to make a complaint or raise a concern. Complaints leaflets were available and the process of making a complaint was described in the patient guide leaflets, which all patients were sent prior to consultation and treatment.
- There was a complaints policy, which had been reviewed within the 12 months prior to our inspection. The service had received no formal complaints over the reporting period from April 2016 to March 2017.
- There was no evidence that concerns raised during the patient feedback survey were actioned. Some of the feedback from the patient survey identified that nutritional choice and provision was not satisfactory. There was no evidence of where this had been discussed or addressed.
- Minutes from the internal executive committee meetings have complaints as a standing agenda item. However, we were told that should a complaint arise this forum would be where it would be discussed and actioned.

Inadequate

Surgery

Are surgery services well-led?

Inadequate

We rated well-led as inadequate because:

Leadership / culture of service related to this core service

- There was a registered manager who reported to the executive committee of partners. There was also a theatre manager, who worked for the hospital, but was also retained by the provider to oversee the running of the surgical service. The registered manager was also the registered manager for the provider's separately registered outpatient facility.
- The registered manager was new to this role. At the time of our inspection, the registered manager had received limited support, development or direction from the executive committee and nominated individual, to deliver the role. At the time of our inspection, they had no development or training programme in place for the registered manager.
- The leadership of CESP (Bristol) LLP – Bristol Eye Hospital relied heavily on the relationship and facilities provided under the service level agreement with the hospital. The provider did not assure themselves that good care and safe standards were always delivered at the hospital. The provider and registered manager relied on the verbal communications of theatre manager at the hospital to ensure services were provided to an acceptable standard. If they were not, there were no documented meetings between the provider and the hospital to address any issues.

Vision and strategy for this core service

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

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

- There was no effective governance framework and the governance arrangements and purpose were unclear. The provider could not ensure that responsibilities were clear and that quality, performance and risks were understood and managed. There were no processes in place to review key items such as the strategy, values, objectives, plans or the governance framework at the hospital. Reliance was placed on the hospitals assurance framework and monthly meetings between the two services where issues would be informally discussed with no documentation of discussions, decisions or actions.
- There was no audit programme in place therefore they did not have assurance of the quality or safety of care provided or processes to ensure continuous improvement.
- The service level agreement between the provider and the hospital was dated 2007, had not been signed and was not monitored or reviewed at regular meetings. A hospital building operational checklist had been completed which related to test certificates and other safety data. This had not been reviewed or repeated since the initial checks were carried out in 2010. Neither documents had been drafted with a review date which meant that any change in risk had not been assessed and updated
- The provider ensured that staff adhered to standard processes such as the National Safety Standards for Invasive Procedures (NatSSIPs). This sets out the key steps necessary to deliver safe care for patients undergoing invasive procedures. We observed a safety brief and the completion of the World Health Organisational surgical safety checklist; all staff were fully involved and engaged with all of the process. We reviewed 11 sets of patient records and saw staff placed completed checklists in all patient notes. However, there were no audits carried out to check compliance and ongoing engagement of all staff with the processes
- There was no assurance that the provider monitored and reviewed the surgical procedures that its consultants carried out at the hospital. Weekly internal executive meeting were held, but these covered

financial issues, car parking and machine service updates. Although there were no terms of reference, we were told that this forum was used as a medical advisory committee and clinical governance group. However, there was no evidence within meeting minutes that demonstrated this occurred. We reviewed eight sets of meeting minutes and could not see evidence of discussions around surgical procedures, NICE guidelines or MHRA alerts.

- There was no risk register for the service provided at the hospital. Senior staff were not aware of the content of the risk register at the service location. There was no evidence that any risks were discussed at the monthly-undocumented meeting between the registered manager and theatre manager at the hospital.
- All of the consultant partners and associate partners working for CESP (Bristol) LLP – Bristol Eye Hospital held indemnity insurance in accordance with the HealthCare and Associated Professions Indemnity Arrangements Order 2014.

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

- The organisation actively sought the views of patients and staff about the quality of the service provided and told us any complaints would be discussed at the weekly executive meeting. The service aimed to answer any complaints within a 24 hour time period. However, they told us they had received no complaints between the reporting period of April 2016 to March 2017
- Patient satisfaction survey results were collated for the period between January 2016 and December 2016. Patients were asked 10 questions about their arrival at the hospital, the facilities, cleanliness, staff and overall recommendations of the service. Scores were lowest on the overall level of comfort, particularly around the food/snack offered. We could not see any discussion of this in the executive meeting minutes.

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

- There was little innovation or service development and no evidence of learning and reflective practice. This was reflected in the minutes of the internal executive meetings.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

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

Action the provider SHOULD take to improve

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. 13(2)Systems and processes must be established and operated effectively to prevent abuse of service users How the provider is in breach of the regulation: Staff did not receive training in safeguarding adults or children and there were no clear systems in place within the service for the reporting of safeguarding.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

12(1) Care and treatment must be provided in a safe way for service users.

12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include –

1. Assessing the risks to the health and safety of service users receiving the care or treatment;
2. Doing all that is reasonably practicable to mitigate any such risk;
3. Ensuring that person providing care and treatment to service users have the qualifications, competence, skills and experience to do so safely;
4. Ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;
5. Ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way.

How the provider is in breach of the regulation:

The provider did not have oversight of the risks to the health and safety of those receiving care and had not ensured that there were actions in place to mitigate such risks. They did not have a system in place to ensure that those providing care and treatment to patients had the qualifications, competence, skills and experience to do so safely.

There was no ongoing oversight of the safety and maintenance of the premises or equipment.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

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

This section is primarily information for the provider

Enforcement actions

audit of practise; the maintenance of records relating to persons employed in the carrying on of the services and the management of the regulated activities carried out by the provider; and, processes and systems to enable the evaluation and improvement of practise in respect of the processing of information relating to governance.