Moorfields Eye Hospital NHS Foundation Trust

RP6

Surgery – satellite sites

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RP601	Moorfields Eye Hospital		EC1V 2PD

This report describes our judgement of the quality of care provided within this core service by Moorfields Eye Hospital NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Moorfields Eye Hospital NHS Foundation Trust and these are brought together to inform our overall judgement of Moorfields Eye Hospital NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

This report is for surgery at Moorfields Eye Hospital satellite sites(all locations other than City Road, St Georges and Bedford).

We ratedsurgery across thesatellite sites as good overall because:

- The satellite sites had systems in place to keep patients safe.
- All patient areas were visibly clean, infection prevention and control processes were in place and equipment had been checked and maintained regularly.
- Medicines were stored and administered safely and records were held securely.
- Patients were receiving effective care and treatment which met their needs.
- Patient outcomes were good and were regularly monitored and discussed.
- Feedback from patients about the care they had received and the way staff treated them was very positive.
- Patients were supported, treated with dignity and respect, and felt involved in their care.
- Patients' needs were met through the way service was organised and delivered.
- Staff morale across all sites was high and most staff felt supported by their managers. Staff felt proud to work at MEH and enjoyed their work.

However,

- There was variable use of early warning scores across the sites.
- At Northwick Park, Ealing and Croydonwe saw patients were waiting too long for their procedure on the day of the surgery, which was a recurring subject of complaints.

Summary of findings

Background to the service

This report is for surgery at Moorfields Eye Hospital satellites (all locations other than City Road, St Georges and Bedford) locations.

Moorfields Eye Hospital NHS Trust (MEH) delivered ophthalmic care from 32 sites across Greater London and Bedford, providing a wide spectrum of clinical services. It delivered care from City Road which was MEH's main location, five district hubs, six surgical centres, 15 community eye clinics and five partnership and network schemes. We inspected the following four satellite locations:

MEH's district hubs

- Moorfields Eye Centre at Ealing located on the same campus as Ealing Hospital.
- Moorfields Eye Centre at Croydon located on the same campus as Croydon University Hospital.
- Moorfields Eye Centre at Northwick Park located on the same campus as Northwick Park Hospital.

MEH's local surgical centres

- Moorfields Eye Unit at Mile End located on the same campus as Mile End Hospital in Whitechapel.

The satellite sites carried out a variety of procedures such as adnexal surgery, cataract, glaucoma and medical retina surgery. Most procedures were day-case surgeries under local sedative, although Ealing and Croydon carried out surgeries under general anaesthetic (GA). Patients who had a surgery under GA were admitted to the host hospital's recovery ward. Additionally, Croydon operated on children who were admitted to a dedicated paediatric day care ward which belonged to the host hospital. There were no MEH inpatient beds at the satellite sites we visited.

In 2015/16 the satellite sites we visited each undertook approximately between 1,100 and 2,450 procedures in the operating theatres for day-case patients. The most common procedure performed was cataract surgery.

During the inspection we visited all pre-operative assessment rooms, anaesthetic rooms, theatres and admission and recovery areas.

We spoke with more than 30 patients and relatives and more than 40 members of staff working at different levels within the service. We reviewed computer systems, documents and patient records. We observed care being given and interactions in clinical and non-clinical areas. We inspected clinical areas and equipment.

Our inspection team

Chair: Dr Peter Turkington

Head of Hospital Inspection: Nicola Wise

The team included CQC inspectors and specialist advisors.

How we carried out this inspection

To understand patients' experiences of care, we always ask the following questions:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Our inspection was announced in advance to the trust. As part of the preparation and planning stage the trust provided us with a range of information, which was reviewed by our analytics team and inspectors.

We requested and received information from external stakeholders including, Monitor, The General Medical Council, The Nursing and Midwifery Council, The Royal

Summary of findings

College of Nursing, and The Royal College of Anaesthetists. We received information from NHS England Quality Surveillance Team, NHS Islington Clinical Commissioning Group, England Specialised Commissioning and NHS Health Education England. We also met with the trust's council of governors.

We considered in full information submitted to the CQC from members of the public, including notifications of concern and safeguarding matters.

Our announced inspection visit took place over the 9 – 13 May 2016. During our inspection we spoke with patients and relatives/friends, who provided feedback on their experiences of using the hospital services. We looked at patient records where it was necessary to support information provided to us.

Whilst on site we interviewed more than 40 staff, which included senior and other staff who had responsibilities for the frontline service areas we inspected, as well as those who supported behind the scene services. We made observations of staff interactions with each other and with patients and other people using the service. The environment and the provision and access to equipment were assessed.

We requested additional documentation in support of information provided where it had not previously been submitted. Additionally, we reviewed information on the trust's intranet and information displayed in various areas of the hospital.

What people who use the provider say

Patient feedback about the service was positive:

- All patients were very positive about staff and the treatment they received. Patients and relatives told us they felt involved in their care and had been given the opportunity to ask questions.
- Patients told us 'service was quick, efficient and friendly', 'everyone was kind, helpful and calm', 'couldn't be more positive', and 'would give them 10/10'.
- The satellite clinics achieved high scores on the NHS Friends and Family Test with scores between97.5% to 98.8%.
- Patients left many positive comments, sometimes naming the staff in their thank you notes. Some comments were 'staff extremely helpful and caring', 'staff were very friendly, and approachable', 'all staff efficient and friendly'.
- Many patients we spoke with knew how to make a complaint. A patient told us they would feel comfortable raising a concern or complaintif necessary, although they had no reason to do so.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure patients' body temperature is monitored during surgery under general anaesthesia as recommended by Association of Anaesthetists of Great Britain & Ireland (AAGBI).
- The trust should ensure Ealing patients' privacy and dignity is protected at all times.
- The trust should ensure Mile End displays clear medical emergency arrangements and every staff member knows the procedure.
- The trust should ensure the surgical safety checklist is well embedded in surgical practice.
- The trust should work to reduce patient waiting times on the day of the surgery.

Moorfields Eye Hospital NHS Foundation Trust

Surgery – satellite sites

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We ratedsafeas requires improvement because:

- At Mile End we found there was confusion about appropriate use of emergency protocol.
- Audit data showed there was variable compliance withNational Institute for Health and Care Excellence (NICE) guidelines on the use of the early warning score (EWS).
- At Ealing waiting area was small, while admissions and recovery areas offered little privacy.
- With the exception of Croydon, the surgical safety checklist was not always fully completed and well embedded.

However:

- There was a good incident reporting culture. All staff knew how to report an incident: they received feedback and lessons were shared.
- All patient areas and theatres were visibly clean.
- Medicines were stored securely and administered safely.
- Infection prevention and control processes were in place and the infection prevention and control (IPC)team regularly audited the satellite sites.
- There was good record keeping. Patient notes were fully completed, well organised and safely stored.
- All sites met the trust's mandatory training completion target.
- Patient safety was protected on a day-to-day basis and patients were safeguarded from harm. Safeguarding processes were followed.

Incident reporting, learning and improvement

- All surgical services at Moorfields Eye Hospital NHS Foundation Trust (MEH) reported 1,077 incidents to the National Reporting Learning System (NRLS) between March 2015 and February 2016. One incident resulted in severe harm, 10 incidents resulted in moderate harm. The one incident resulting in severe harm was a clinical assessment incident. The most commonly reported incident category was documentation (383, 36%) followed by medication (265, 25%). Analysis of the date showed there was an overall downward trend in the numbers of documented incidents reported within surgery.
- Incident data provided by the trust showed that between October 2015 and January 2016 there were43 reported incidents across the four satellite sites that we inspected. There were 24 incidents at Croydon of which 19 resulted in no harm, three had minor impact and two were near misses. There were 11 reported incidents at Ealing of which six resulted in no harm, three incidents

had minor impact, one had moderate impact and one near miss. At Northwick Park there were seven incidents of which one had minor impact and the rest resulted in no harm. There was one incident reported at Mile End which resulted in no harm.

- Between March 2015 and February 2016 the trust reported one never event. Never events are serious incidents, which are wholly preventable as guidance and safety recommendations are available that provide strong systemic protective barriers at a national level. The incident occurred in November 2015 at one of the satellite sites and related to a wrong type of intra-ocular lens (IOL) inserted into the eye during cataract surgery. The never event was fully investigated and we reviewed the report which identified the root cause and contributory factors that led to the incident. The investigation report outlined a number of recommendations and actions including an email to all staff involved in cataract surgery and arrangements to share learning through all service meetings and local team meetings.
- However, during the inspection, not all staff we spoke with across the four sites knew about the never event. Some staff knew about the changes to the process of handling IOL's but did not know the reason behind the change. Some staff told us they received email communication following the never event to remind staff of the changes implemented.
- We observed cataract surgeries at three out of the four satellite sites we visited and observed changes to the cataract surgery practice had been implemented to prevent another never event from happening.
- All staff that we spoke with were clear about their responsibilities to raise concerns and report incidents, including near misses. They knew how to report an incident and were able to demonstrate it on the hospital e-reporting system. Staff said that if something went wrong they would always inform their matron or sister in charge.
- All staff we spoke with told us they received email and verbal feedback after they reported an incident. They also attended regular meetings, such as quarterly clinical governance half day events, senior nurse and local team meetings, where feedback from incidents was shared and learning was encouraged. Meeting minutes were stored in a shared drive where staff that missed a meeting could access them. Staff at Ealing and Northwick Park told us that if a staff member did not attend a team meeting they received an email with the meeting details. Staff were also informed about incidents that occurred at other sites through regular MEH wide communication that was sent to all staff.
- The trust had a clear incident and serious incident (including never events) reporting policy and procedure. The trust's identification of serious incidents was in line with the Serious Incident Framework, published by NHS England in March 2015.
- Serious incidents were reviewed at a weekly serious incidents panel meeting. The meetings were usually chaired by a clinical director or executive director. We saw three examples of serious incidents panel meeting minutes where the panel discussed the incident, considered whether an incident was possible or actual serious incident or never event, discussed the need for openness and reviewed risk. When appropriate, they appointed a lead investigator and the investigation team identified immediate actions.
- Serious incidents were investigated by a lead investigator (usually the manager of the area in which the incident occurred) according to the principles of root cause analysis (RCA).
- The trust had a 'Being Open and Duty of Candour' policy. Duty of candour (DoC) requires providers of healthcare services to be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- Clinical and administrative staff received training on the duty of candour in November 2015 and all clinical and managerial staff were required to read the trust's duty of candour policy. DoC featured in the quality newsletter (September 2015 issue) sent to all staff. Additionally, the trust created an infographic poster version of the policy's key points as a quick reminder to all staff of their duty and requirement to be transparent, open and honest. We saw this being displayed in staff areas.
- The trust explained the majority of duty of candour training was ad hoc and usually followed a patient safety event whereby significant harm had occurred. Following an incident, the risk and safety team discussed with clinicians aspects of the duty of candour and any further requirements necessary. The serious incidents panel also discussed requirement for being open during the weekly incidents review meeting.

Requires improvement

Are services safe?

- The trust's incident management system prompted staff reporting incidents to complete mandatory sections regarding being open and duty of candour.
- Staff across sites had knowledge of their responsibilities under duty of candour and some gave us examples of when this was applied; the patient involved was offered an explanation and apology.
- We saw an example of when duty of candour was applied in the investigation report for the never event. The patient was immediately informed of the error and apologised. They were also formally notified, given an explanation as to what had happened and the opportunity to speak. The report noted that the patient was very complimentary regarding the level of openness that had been shown.

Safety thermometer

- Performance data for surgical services provided by the trust for the reporting period 2015/16 showed 99% of patients at Ealing were assessed for risk of venous thromboembolism(VTE) prior to an operation under general anaesthetic. Croydon achieved 95.8% compliance against the trust's target of 95%. No VTE assessments were carried out at Mile End and Northwick Park, as the trust policy stated it was not required for day case ophthalmology patients who had a procedure under local anaesthetic.
- Adult patients who had their surgery done under general anaesthetic at Ealing were recovered in the host trust recovery area and then returned to the Moorfields day care unit where they were cared for by Moorfields trained staff. At Croydon, adult patients who had their surgery done under general anaesthesia went to the host trust recovery area and then to the host trust day surgery area for discharge.
- Staff told us they undertook pressure ulcers assessment when necessary using Waterlow pressure ulcer risk assessment tool. We did not have the opportunity to see a completed form.

Cleanliness, infection control and hygiene

- The trust had an infection, prevention and control (IPC) team which regularly audited MEH sites. We saw evidence of various infection control audits taking place.
- The most recent yearly infection control audit carried out by the IPC team, which included theatres, day surgery, recovery areas, utility room, waste handling and policy awareness, amongst others, showed Ealing was 97% compliant and Croydon was 93% compliant against the trust's target of 85% or above. Mile End was partially compliant and achieved 84%. The areas in which they fell short of the required standard were mainly around missing labels, posters and IPC information, incorrect storage of products, and cleanliness and maintenance of some items.
- Staff told us the IPC team was good; carrying out re-audits and following up specific issues identified with staff. Audits that we looked at had action plans in place with completion dates and a specified responsible person. We reviewed three IPC action plans and saw staff completed most action plans in a timely manner.
- In November 2015 the trust conducted a trust wide sharps safety audit to establish whether sharps were disposed of in a safe manner. Data for Croydon, Ealing and Northwick Park showed 100% compliance at day care surgery. Mile End achieved 97.92%. The trust compliance target was above 95%. The area where the Mile End site slightly fell short of the required standard was around sharps containers not having the temporary closure in place when the container was left unattended or during movement. During the inspection we observed that all sharps containers had a temporary closure in place and were safely used and assembled.
- Clinical waste generated by MEH was managed by the host hospitals and this arrangement was covered by the service level agreement. Staff told us there were no issues with the waste management.
- All staff we observed washed their hands, and used hand gel and gloves as required. We also observed all staff complying with 'the bare below the elbow' standard to enable good hand washing and reduce the risk of infection. Monthly hand hygiene audit data between April 2015 and April 2016 for the four sites showed that compliance in theatres and day care areas was usually 100%.
- Hand washing soap and alcohol hand rubs were in good supply and we saw instructions for their use clearly displayed next to and on the soap/alcohol dispensers. Alcohol wipes to clean slit lamps and disposable gloves were readily available in the consultation rooms we visited.
- At Mile End, day care area had bedded bays separated by fabric curtains which were visibly clean. Staff explained these were changed by the host hospital but were unsure how frequently that happened. However,

staff explained they had been changed recently. There was a disposable curtain at Ealing's admission/recovery lounge which was changed in March 2016 and had a replacement date.

- The trust's rate of endophthalmitis post cataract surgery between January 2014 and June 2015 was 0.02%, which was better than the standard of 0.08%. Between January and December 2015 there was one case of non-cataract post-operative endophthalmitis reported at Croydon. There were no endophthalmitis cases reported at Ealing and Mile End sites. Staff explained they completed an incident form for every endophthalmitis case and these were investigated by the IPC team who performed root cause analyses.
- The trust had a Methicillin-Resistant Staphylococcus Aureus (MRSA) screening policy which stated that day case ophthalmology patients were exempt from routine MRSA screening.If a patient was previously identified as colonised with or infected by MRSA they were screened for MRSA. Between April 2015 and Match 2016 there were no reported health acquired infections or MRSA and Clostridium Difficile (C. Diff).

Environment and equipment

- Resuscitation trolleys, apart from at Mile End, belonged to the host hospitals although MEH staff regularly checked them. Trolleys were secured with a breakable seal which was opened weekly to check the trolleys' content. Equipment that was on the trolleys such as defibrillators were checked daily. Croydon had resuscitation equipment for adults and children. Records for the last three months showed the checks were done regularly and we did not observe any omissions.
- Staff told us they had the equipment they needed to do their jobs and any issues were reported to EBME (Electro-Biomedical Engineering Department) who promptly sent engineers out and carried out required repairs. EBME was also responsible for maintenance of the equipment.
- Staff calibrated tonometers (instrument for measuring the fluid pressure inside the eye) and HbA1c machines (used to measure blood glucose levels) every day.
- Clinical and domestic waste bins were available in all clinical areas we visited. All bins had clear labelling for segregation of clinical and domestic waste, and we observed staff appropriately disposing of waste.
- Northwick Park, Ealing and Croydon had a dedicated eye theatre and day care area, while Mile End used the theatre onsite every Tuesday and Wednesday. The other days of the week the Mile End unit was used by the host hospital. This meant that MEH staff had to store away their ophthalmic surgery equipment, a MEH crash trolley and patient information leaflets every Wednesday evening.
- Staff across all sites reported good relationships with the host hospitals in terms of maintenance of the environment. Staff we spoke with knew how to report a fault and explained that the process was straightforward. However, Mile End had one ongoing issue with a leakage which staff had reported on numerous occasions to the estates department of the host hospital. This was added to the local risk register and staff were unsure what action was being taken. Also, Croydon added issues with having limited control over elements of the environment to their risk register, such as maintenance of the building and explained they had ongoing issues with air conditioning units within main clinics.
- Waiting, admission and recovery areas at Croydon, Northwick Park and Mile End looked clean, clutter free, spacious and quiet. At Ealing, the admissions and recovery area, although clean, was small and offered little privacy.
- As Northwick Park did not carry out procedures under general anaesthetic, the recovery room was utilised as a storage room. A number of staff reported a lack of space at Northwick Park and Ealing sites.

Medicines

- We found that drug cupboards in treatment rooms were clean and tidy, with cupboards labelled detailing contents within. Keys to the drug cupboards and PODs (Patient's Own Drugs) lockers were held by registered nurses and doors to the rooms housing medicines were locked with restricted access.
- The temperature of fridges used to store medicines were monitored and recorded to ensure medicines were kept at the required temperature. We saw evidence of action being taken if temperature was out of range. At Croydon fridges were automatically monitored at City Road and the matron received a daily report. If the temperature was out of range, staff received an immediate alert.
- There were no controlled drugs (medicines subject to additional security measure) stored or administered at

the day care areas. Controlled drugs (CDs) stored in theatres were audited on a daily basis, with a separate signing sheet. However, we found that at Croydon the CD register was not completed correctly on two occasions in May 2016. We found that staff did not double-sign an entry in the register to provide evidence of an authorised witness when a CD had been administered or disposed.

- Management and delivery of medication at the satellite sites was provided directly through MEH pharmacy staff based on site or by the pharmacy services of the host hospital. At Mile End medication was supplied by City Road.
- There was a policy in place to support the use of Patient Group Directions (PGDs) and we saw evidence that these were signed by authorised personnel, in date and appropriately audited. We saw a database with a list of staff who could administer medication using PGDs at each site. At Mile End we saw that all PGDs apart from one were correctly signed off.
- Staff had access to the British National Formulary (a pharmaceutical reference book that contains information and advice on prescribing and pharmacology) as well as all policies/information relating to medicines management, including the antimicrobial formulary.
- Staff competencies for prescribing, dispensing and administering medicines were assessed during induction processes provided by the trust, through the intranet portal. All staff attended annual medicines management training.
- Staff understood and demonstrated how to report medicines safety incidents. Once reported, an incident was then escalated and the learning was fed back through various channels, such as medicines safety newsletters, emails and monthly meetings chaired by a matron or dedicated nurses in charge of medicines management/drug safety.
- Allergies were recorded on the drug charts, alongside other sections such as a VTE risk assessment, medicines reconciliation section and suitability for self-administration. MAR (medicine administration record) charts were used for inpatients.
- Prescriptions were generated on an IT system called OpenEyes, for medication on discharge. Pre-labelled eye drops and tablets were supplied by nurses on discharge. Discharge information provided to patients had a section on eye drops. Also, to help patients identify different drops, eye drop bottles were colour coded. We also saw that patients were provided with a separate large print sheet to explain when to reduce doses of dexamethasone eye drops.

Records

- We reviewed 27 sets of medical records across Mile End, Ealing and Croydon. All the records we reviewed were clear and legible and all checklists and proforma were completed fully. We saw that risks were documented as well as benefits and informed consent was obtained. Surgical notes were thorough and comprehensive. Information about dressing and post-operative care instructions were clear and there were ID stickers on each page.
- All the records had well laid out pathways with clear pre-operative assessment documentation. The records had a standard proforma used by the admitting nurse or health care assistant (HCA) to check if there had been any changes since the pre-operative assessment that might prevent surgery from going ahead. Patients' observations such as blood pressure, body temperature and pulse rate were recorded before the operation, including blood glucose levels for diabetic patients.
- At all locations patient records were kept securely either in a lockable cupboard or areas only accessible by staff. Each day the paper records from satellites are transported to MEH City Road site. The exception was Croydon as the site was paperless which meant that all records were electronic and any paper notes were scanned at the end of each day, uploaded onto the OpenEyes electronic system and the paper was shredded.

Safeguarding

- The trust had separate safeguarding policies and procedures for adults and children at risk. The policies, advice and details of contact leads to support staff in safeguarding referrals was available on the MEH intranet. Also, all sites we visited had a designated safeguarding liaison nurse.
- Staff gave us examples of when they had raised a safeguarding concern, for example in relation to patient's self-neglect, psychological abuse or neglect by a carer. Also, staff gave us an example of when they flagged a patient's electronic record to ensure that all staff were aware there was a safeguarding concern in relation to this patient.

Requires improvement

Are services safe?

- Staff told us that adult and children safeguarding alerts were made to the patient's local authority. They explained that they would alert their manager if they had any concerns. Staff we spoke with knew how to report a safeguarding concern and showed us the safeguarding concern form on the MEH intranet. They told us that following a referral they received feedback.
- Data provided by the trust as of 1 May 2016 showed 100% completion rate at Croydon for safeguarding training level 1, 2 and 3. Data provided for Moorfields North (north and east London satellite sites including Mile End, Northwick Park and Ealing) showed the completion rate for safeguarding training level 1 and 2 was between 89.5% and 100% against the trust's 80% target. Completion rate for safeguarding training level 3 (required for staff with strategic management and leadership for safeguarding) was 66.7% with further staff to be trained on a rolling programme. We reviewed safeguarding adults at risk meeting minutes from August, October and December 2015, which showed that compliance with the safeguarding training was a standard item on the agenda. To improve training completion amongst staff the trust offered a bespoke safeguarding adults training course for satellite sites.
- Every two months senior staff, including matrons and safeguarding leads attended a safeguarding adults at risk meeting where referrals made to adult social care were discussed and any learning and actions were taken. For example, following one of the meetings the group identified that the adult safeguarding policy did not include the forced marriage guidance helpline information. We saw evidence that this was actioned; helpline information was added.
- The trust recognised that domestic abuse was one of the key safeguarding areas for MEH and run separate domestic abuse training. At Croydon 40 staff members attended the training while Ealing, Mile End and Northwick Park had not yet received the training. The training had been prioritised for sites where urgent care services are provided. This service was not provided at Ealing, Mile End and Northwick Park. Domestic abuse awareness was briefly included in Level 1 and Level 2 safeguarding children training and level 1 and 2 safeguarding adult training. We saw safeguarding and domestic abuse awareness posters for male and female victims.
- Information provided by the trust showed all staff at satellite sites, including volunteers, had the appropriate Disclosure and Barring Service checks.
- Staff at Croydon liaised with the host hospital's safeguarding children lead nurse regarding safeguarding concerns and for advice. When staff suspected an injury they ask a child to be sent to the host hospital's emergency department for examination.

Mandatory training

- The trust had a policy on mandatory and statutory training which was in date and outlined the responsibilities of individuals and managers in ensuring the trust complied with the training target. The policy also outlined personal compliance level required for each individual member of staff was 100% when they were actively working, so not, for example, on maternity leave or long term sick leave. The trust completion target for most training was 80%.
- Mandatory training covered a range of topics such as equality, diversity and human rights, Mental Capacity Act, safeguarding, life support, trust and local induction, moving and handling, fire safety, infection control and conflict resolution, amongst others.
- Bank and agency staff also had to complete mandatory training essential to their role and this requirement was ensured by the agency and bank staff provider. Any additional training required was provided by the trust. Volunteers had to complete the following mandatory training: safeguarding children level 1 and safeguarding adults, information governance, and fire safety.
- Training completion data provided by the trust as of 1 May 2016 showed the following overall completion rates across all mandatory training and all staff groups: 90% completion at Moorfields North sites (including Mile End, Northwick Park and Ealing) and 87% at Croydon.
- Staff told us that it was their responsibility to ensure they were up to date with mandatory training. All training was recorded on MEH electronic system and each member of staff had their online training folder. Staff told us they received an email when they were overdue for their mandatory training.
- Bank and agency staff that we spoke with told us they received induction and orientation when they first started. At Croydon induction checklists were stored onsite. Staff at Mile End explained they did not store a copy of the induction checklist for bank and agency

staff. Staff told us they tend to use the same agency staff therefore they were confident staff completed their induction. This however was not in line with the trust's induction policy.

- New nursing staff underwent a week's in-house ophthalmic training at City Road. Following the training the staff followed a competency matrix which was recorded on paper and online. Also, following the training staff were allocated a mentor and were teamed up with a link nurse with whom the new member of staff usually worked. Staff we spoke with were very complementary about the induction programme they completed on joining the trust.
- Staff with managerial responsibilities told us they received an email when staff were overdue with their mandatory training. Staff told us that when they did staff rotas they tried to plan and manage their resources effectively to ensure staff could be released to attend training. Staff across sites confirmed they were given time to complete their training.

Assessing and responding to patient risk

- MEH adopted the World Health Organisation's (WHO) surgical safety checklist which was thought to be suitable for their setting. Additionally, before the start of operating lists all staff involved in patient care (consultant surgeon, registrar, operating department assistant, anaesthetist, scrub nurse, health care assistant and day surgery nurse) were expected to have a briefing to discussed each patient, potential and actual safety issues, decided the list order and type of anaesthetic used. At the end of an operating list the staff was expected to have a debrief to review any issues, answer any concerns identified by the team and discuss specific incidents.
- At Ealing, Mile End and Croydon we observed the WHO surgical safety checklist in practice. The standard and thoroughness varied between sites. We observed that at Ealing the sign-out (the final stage of the WHO checklist) was not always fully completed while at Mile End the sign out did not appear to be well embedded as it was not clearly verbalised and not everyone in theatre was involved. At Croydon the WHO checklist was very thorough, all three stages were clearly verbalised with all theatre staff participating.
- Briefing and debriefing are additional components of the surgical safety checklists (also referred to as 'five steps to safer surgery'). We observed briefing at Ealing and Croydon and debrief at Croydon. The inspection team did not have the opportunity to observe debriefing at other sites. The most recent satellite site audit data provided by the trust from 2014 showed briefing was practiced at Northwick Park, Mile End and Ealing (Croydon was not part of the audit). However, the audit demonstrated that the theatre team left theatre at the end of operation lists without any debriefing. Briefing and debriefing practice had not been re-audited at the satellite site since.
- All patients had their surgical site marked by a surgeon during pre-operative consultation and before dilating drops were applied to the patients' eyes by the nursing staff.
- The trust carried out a WHO checklist audit across ten sites which aimed to identify how the trust adhered to the prescribed safety checks. The report was dated February 2015 however it was not clear when the audit was carried out. The audit looked at intraocular lens insertion surgery during cataract surgery but only focused on the stage one (sign-in) and stage two (time-out) of the WHO's three stage process. The data showed 100% compliance with the sign-in practice across the sites. The data showed overall compliance with 'time-out' stage between 82% and 98% across all ten sites that were audited.
- All patients had a pre-operative assessment for their general fitness to proceed undertaken by a nurse prior to their surgical admission. This ensured that any patients at increased risk of having surgery were identified. If a patient was identified as high risk they underwent a pre-operative assessment by an anaesthetist.
- Staff used red wristbands to indicate that a patient had an allergy. We observed staff double checking patient allergies before a procedure.
- At Croydon the host hospital staff did the pre-operative assessment and recovery of all children and MEH patients who were under general anaesthetic (GA); MEH staff only managed these groups of patients when they were in the anaesthetic room and theatre. At Ealing, MEH staff did pre-operation assessment but the recovery was done by the host hospital where patients were admitted to the host hospital's day surgery ward. Since the recovery area at Ealing was too small for a patient to lie down, Ealing had an agreement with the host hospital to provide beds for any patients who needed extra care following mild sedation.

Requires improvement

Are services safe?

- Surgery sites were effectively using the early warning scoring (EWS) system for identifying and monitoring the deteriorating patient. During our visit we reviewed 27 patient records and we observed appropriate use of the EWS for the peri-operative monitoring of patients.
- Between May and August 2015 the trust completed a yearly EWS audit to determine whether the system was in compliance with NICE guidelines (Acutely ill patients in hospital: recognition of and response to acute illness of adults in hospital', CG50). The results varied between 40% and 100% against the trust's 100% completion standard. In October 2015 the trust re-audited Mile End and Northwick Park, which showed improvement in some areas although the scores still varied between 40% and 100% and were less than optimal. The trust conducted another spot check at the beginning of 2016 which showed Mile End and Ealing to be 100% compliant and Northwick Park achieving between 60% and 100%.
- All theatre staff were trained on resuscitation equipment as part of their induction. Anaesthetists and operating department practitioners (ODPs) were trained in advanced life support (ALS).Additionally, Croydon theatre staff completed paediatric immediate life support (PILS) training.
- The anaesthetist and/or ODP present and nursing staff attended to an unwell or deteriorating patient, with access to a crash trolley. Patients requiring further intervention at Northwick Park, Ealing and Croydon had access to the host hospital's crash team and the host trust crash team staff would refer medical emergencies to their respective A&E departments.
- In case of medical emergency Mile End staff had to contact London ambulance service directly through a 999 call as they did not have access to a crash team. This arrangement could lead to a delay in patients accessing the right and timely care. Although anaesthetists and ODPs were ALS trained there were periods of the day where they were not always present. Staff told us that once doctors complete their theatre list, they would leave for the day therefore only nursing staff were present. All nursing staff had adult basic life support (BLS) training and senior nurses had immediate life support (ILS) training. They would have to wait for a paramedic for any further intervention. Also, we found there were two types of signage next to the phones explaining who should be contacted in case of emergency, which we found might be confusing to staff. MEH signs stated staff should call the anaesthetist and 999 while host hospital's signs referred to a hospital 2222 emergency number. Staff that we spoke with correctly explained the MEH emergency call protocol but one member of staff stated that in case of medical emergency they would call 2222 number anyway. Senior staff said they felt comfortable with the current procedure as they were not aware of any instance when patient had come to harm and when needed the protocol was correctly followed.

Nursing staffing

- Senior staff told us that they did not use an acuity tool to establish nursing staff levels. The trust explained there was no acuity tool for ophthalmic nursing staffing but they were working to develop one. The staffing skills mix and staffing levels were discussed yearly before the budget was finalised and agreed with clinical leads. As a minimum, day care areas had a staffing ratio of one member of staff to three patients (usually one band 3, one band 5 and one band 6). Theatres usually had one nurse trained in anaesthetics or ODP, two scrub nurses, a circulating nurse and a HCA.
- When planning staffing levels consideration was given to patients who had special needs e.g. dementia patients, patients with learning disabilities and patients with mental health issues who needed additional supervision and care. To help and plan staffing levels pre-assessment clinics communicated information regarding this group of patients to day care staff.
- The day care areas and theatres we inspected had sufficient numbers of nursing and support staff with an appropriate skill mix to ensure patients received the right level of care.
- The most recent data provided by the trust show that at Moorfields North the established staffing levels in March 2016 was 113.6 WTE (whole time equivalent) while actual staffing level was 101 WTE. The 12.6 WTE vacancy rate was mainly covered by bank staff (0.05 covered by agency). At Croydon the established staffing level in March 2016 was 18 WTE against actual staffing level of 13.4. Bank staff covered all 4.5 WTE vacancies.
- Senior staff explained they had difficulties in recruiting ophthalmic nurses and that the trust had been actively recruiting nursing staff with limited success. The staffing issues were added to Croydon's local risk register.

Requires improvement

Are services safe?

- Staff at Ealing, Mile End and Croydon told us they felt stretched and explained that there was no room for sickness although did not express concerns around patient safety. Northwick Park staff reported no issues with staff levels.
- Any extra staff required on the day of surgery was arranged by a matron or a senior staff members. Staff explained that if someone was on annual leave they would usually cover the shift with MEH bank staff. Staff told us bank nurses were the preferred choice to cover shifts followed by agency. The majority of agency nurses regularly worked at MEH and were required to have ophthalmic training. Senior staff at Ealing and Northwick Park explained they met with the agency staff manager to discuss their needs and training requirements.
- At Moorfields North staff was moved between sites to cover for planned leave or long term sickness. Senior staff from Moorfields North told us they supported each other when they were short of staff and they use their staff flexibly. Most staff we spoke with did not mind moving across sites and saw it as opportunity to help other teams. Senior staff explained nurses were flexible and their skills and training allowed them to work across day case areas and outpatients. Some staff at Croydon explained they did not get much support from the trust or other satellite sites and they had to rely on bank and agency cover. Staff told us that on two occasions they had to cancel a theatre list due to agency staff cancelling their shift at the last minute.
- Bank or agency staff were used to covered sickness or, if available, staff from other satellite sites were asked to assist. If this was not possible a matron, senior sister or on-call nurse from the outpatient clinic covered the shift.
- Medical staff said they were happy with their bank and agency staff and they usually worked with the same nurses.

Surgical Staffing

- Rotas for medical staff working at Moorfields North were formulated at City Road. When sites were short staffed medical staff from City Road travelled to satellites to support day case activity.
- The most recent data provided by the trust for the North satellite sites(across all MEH sites as the data set did not allow to check staffing rates per site) showed that the established staffing level in March 2016 was 285.4 WTE while actual staffing level was 251.5 WTE. Vacancy rate across all surgical sites was 33.8 WTE. At Croydon and Moorfields North any vacancies were filled by agency staff.
- Theatres at satellite sites usually operated between Monday and Friday (Croydon also on Saturdays) between 7:30am and 5pm. If a consultant was needed outside of the satellite's operating hours patients were told to contact City Road or attend A&E department at City Road for any urgent issues.
- All surgeries were consultant-led and a consultant supervised trainees and fellows.
- The trust told us the host trusts' anaesthetists were trained in advanced life support (ALS) and Croydon theatre staff completed paediatric immediate life support (PILS) training. At Ealing the host hospital provided anaesthetists for general anaesthetic lists only, while at Croydon the host hospital provided adult and/ or paediatric anaesthetists for all lists.

Major incident awareness and training

- The trust had an emergency preparedness, resilience and response policy and a business continuity plan for surgery service at satellite sites. The document included the risks specific to the clinical areas and the actions and resources required to support recovery. It listed possible risks that could affect the provision of care and treatment.
- The satellite sites had a role in the event of full or partial loss of surgical capacity at City Road. The business continuity plan clearly listed facilities at various satellite sites and the type of surgeries they could perform. The plan did not include the Croydon site.
- The trust's emergency planning lead ran monthly incident management training attended by directors on-call, senior managers on-call and site cover nursing staff, which focused on an overview of the business continuity, incident management and business continuity plan. The emergency planning lead also ran business continuity and emergency preparedness exercises which covered various topics such as the IT disaster recovery plan, pandemic influenza desk top exercise or exercises to improve staff familiarity with a satellite site business continuity plan. Some staff we spoke with confirmed that they had attended adisaster preparedness scenario exercise in recent months.

Requires improvement

Are services safe?

- Staff explained that in the event of disruption at their site patients appointments would be rescheduled to other sites, prioritising urgent cases.
- Since Croydon was paperless and relied on IT infrastructure, possible IT failure was added to their local risk register.
- Staff gave us examples of when they had to deal with real life situations such as a power cut or problems with water supply, which were dealt with efficiently without effecting patients care and treatment.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We haverated effective asgood because:

- Evidence based care and treatment was planned and delivered to patients in line with current evidence based guidance, standards and legislation.
- All sites apart from Mile End had arrangements in place to feed patients.
- Staff were competent to deliver good quality care.
- All satellite sites met the trust's appraisal target.
- Multi-disciplinary work was in place to ensure patients' care was well managed.
- Patients were supported to make decisions. They were well informed about surgical procedures.
- All staff we spoke with were aware of what action to take if they thought patients lacked capacity and needed support.

However,

- We saw that the body temperature of an adult patient under general anaesthetic was not monitored as recommended by Association of Anaesthetists of Great Britain & Ireland (AAGBI).

Evidence based care and treatment

- Trust wide and local policies, standard operating protocols (SOPs) and procedures were available on the trust's intranet. Staff demonstrated how they could access them.
- Surgical services used a combination of guidelines and best practice such as National Institute for Health and Care Excellence (NICE), Centre for Advanced Eye Care (CAEC) or Royal Colleges guidelines to determine the care and treatment provided. Clinical governance and clinical audit teams were responsible for reviewing the policies while the head of clinical governance was responsible for managing all clinical guidelines, protocols, and SOPs and uploading them to the intranet once approved. We reviewed a sample of policies and guidelines which were in date and evidence based.
- The trust's clinical audit and effectiveness committee also reviewed NICE guidelines to identify those that were relevant for the trust. These guidelines were shared with clinical leads to determine relevance and appropriate actions.
- Staff explained that they learned about updates to the relevant updated policies and procedures during the quarterly clinical governance (CG) meetings. New policies/protocols were a regular agenda item of the service specific CG meetings. If a staff member did not attend the meeting they were sent the meeting minutes.
- A recent recommendation from the Association of Anaesthetists of Great Britain & Ireland (AAGBI) is that body temperature of patients under anaesthesia must be monitored if they undergo procedure which lasts more than 30 minutes or the procedure is high risk. Additionally, NICE guidance and The Royal College of Anaesthetists recommends warming to be used for all procedures over 30 minutes (or in those at high risk of hypothermia). At Croydon we saw warming was used for an adult patient under anaesthesia but their body temperature was not monitored.
- Since MEH is a single speciality hospital, many national audits did not apply. All satellite sites contributed the posterior capsule rupture rates data to the National Ophthalmology Database (NOD). Also, Croydon provided age-related macular degeneration (AMD) data to NOD and diabetic eye screening programme (DESP) information to the national DESP.
- The trust had a clinical audit policy which outlined the audit cycle and aimed to enable staff to complete clinical audit activity. The trust audited their practice against standards and guidelines set by the Royal College of Ophthalmologists (RCO). The clinical audits we saw were revalidation audits carried out by trainee doctors or regular audits as required by guidelines, for example toric intra-ocular lens (IOL), cataract surgery, posterior capsule rupture or retina vein occlusion audits. All audits had recommendations, action plans and, when applicable, improvements to the service or

patient pathway were suggested. Often audits included re-audit proposal dates to assess whether implemented changes had made a difference. We saw a number of such re-audits.

- The trust's clinical audit team carried out annual audits to check compliance with various policies and procedures such as early warning score audit, clinical record keeping audit, and patient consent audit. We saw that when issues were identified an earlier re-audit was scheduled. The clinical audit and effectiveness committee meet every two months to discuss progress of the audit and effectiveness of the programme.
- Staff told us clinical audit findings were presented at service specific CG meetings. We saw CG meeting minutes which showed this was a standing agenda item.
- We saw limited local quality audit activity across the satellite sites we visited. Senior staff told us they carried out spot checks such as hand hygiene, cleaning or record keeping. We saw that monthly cleaning and hand hygiene audits took place but we saw no evidence that any corrective action followed. Senior staff told us if they saw someone falling short of the required standard they would immediately address it with the staff member in question.
- Surgical safety checklist audits were not routinely and regularly conducted. We saw one WHO checklist audit that was carried out before February 2015 but it focused on the first two of the three step surgical safety process. Briefings and debriefings were also not regularly audited. The last audit was completed in 2014 and although it concluded the debriefings in theatres did not occur we saw no evidence this practice was re-audited.

Pain relief

- Pain scores were based on the numeric graphic rating scale (NGRS) from the Royal College of Physicians.
- The trust carried out an audit of pain scores of patients in post-operative recovery. The review explained that the majority of ophthalmic procedures cause little pain however some required potent analgesics. The audit data showed there had been an improvement in the management of pain in 2015 compared to 2010 results. In 2015 only 6% of patients experienced a pain score greater than four (on the scale of 0 to 10, with 10 being the greatest) against 14% in 2010. In the 2015 review 89% to 93% of patients graded pain as 0. The average time taken to reduce the pain score greater than 4 had been 15.4 minutes compared to 14.5 minutes in 2010. The study explained this was due to one patient where the pain took 60 minutes to subside. All patients with pain score greater than 4 were treated with opioids, for example codeine or fentanyl.
- Staff told us that following procedure and before discharge, patients were asked about pain and they did a visual assessment to see if the patient was in discomfort. We have not seen this being recorded in patients' notes. We observed staff giving advice to patients during discharge and advised patients to take their normal painkillers if they experienced pain.
- In 2016 the trust carried out a study to establish which pain relief agent(s) were most effective in providing anaesthesia for patients receiving elective intravitreal injections to improve the patient experience. The study made recommendations and these were to be re-audited.

Nutrition and hydration

- At all sites we visited patients were offered drinks such as water, tea of coffee. However, provision of food varied between sites despite some patients spending over six hours in day surgery units.
- At Ealing staff told us they could arrange for sandwiches or biscuits. We saw a patient was offered a sandwich and another patient told us staff offered them food.
- At Northwick Park staff told us they offered sandwiches to patients and relatives, especially if they were last on the list or waited a long time for their procedure.
- At Croydon, patients for the morning appointment were offered biscuits. In the afternoon patients were offered a menu where they could choose their refreshments. Patients said the menu was good and they were always offered a drink. Staff at Croydon could also arrange halal or kosher option sand staff gave an example of when they had to arrange a gluten free sandwich.
- Patients at Northwick Park and Croydon told us they were happy with refreshments given.
- At all sites staff told us they monitored and managed diabetic patients and ensured they were safe.

Patient outcomes

- The trust monitored core outcomes such as posterior capsular rupture (PCR) and/or vitreous loss, visual acuity outcomes after cataract surgery, visual harm such as a visual acuity loss of a doubling or worse of the visual angle. They also monitored secondary outcomes

such as deviation from predicted post-operative refraction, post-operative high astigmatism, endophthalmitis and need for repeat surgery among others.
- Data provided by the trust showed their outcomes were comparable or better than standards set by the National Ophthalmology Database (NOD).
- Posterior capsule rupture (PCR) is a complication in cataract surgery. PCR standard rate was 1.92% while the trust's target was 1.3% or lower. In 2015/16 the PCR rate in cataract surgery was 1% at Ealing, 0.9% at Northwick Park and 0.6% at Mile End. At Croydon, PCR rate between April and September 2015 was 0.9%.
- In 2015/16 at Ealing there were nine repeat operations on the same eye within a week the first procedure. There were five repeat operations within a week at Northwick Park and three at Mile End. Data for Croydon was not provided.
- The trust's target for endophthalmitis was 0.083% for cataract procedures. In 2014/15 the endophthalmitis rate for cataract across surgical services was 0.02%. Between April 2015 and March 2016 there were no endophthalmitis cases following cataract surgery across the four sites we inspected. There was one non-benchmark endophthalmitis case in Croydon followingtrimming of exposed Supramid suture.
- Staff told us if there was a cluster of incidents related to clinical outcomes for example aseries of endophthalmitis casesthey would employ an external specialist to investigate the cause.
- Medical staff told us thatthey compared their cataract outcomes against their own data and the national and international outcomes for quality assurance.
- The percentage of ophthalmology surgery performed as day case surgery was 96.5% against thetrust's target of 90%.
- There were no emergency readmissions within 30 days of discharge at the satellite locations in 2015/16.
- The satellite sites did not collect PROMs (Patient Reported Outcome Measures) whereby patients are asked to complete a questionnaire (both before and after treatment) to ascertain the patient's perceived improvement in health.
- Surgical services achieved 100% diagnostic waiting times of the six weeks standard.
- The trust target of 70% or more patients to be booked to the named clinician in 2015/16 was achieved in 76% at Northwick Park, 62% at Ealing, 31% at Croydon and 6.1% at Mile End.
- At the time of the inspection the sites we visited did not run any clinical trials related to surgery, rather assisted in recruiting patients for other sites. Northwick Park was planning to run a trial related to glaucoma and this was at the recruitment stage.

Competent staff

- The trust had appraisal and revalidation, and induction policies which were in date.
- The medical director was the trust's responsible officer for revalidating medical staff. Data provided by the trust showed 98% of doctors were revalidated. Clinical directors appraised consultants, trainee doctors and trust fellows. The trust organised an annual training day for current appraisers to update existing skills and train new appraisers. As part of their appraisal and revalidation, medical staff carried out various clinical quality audits.
- Staff we spoke with told us that they had regular annual appraisals which included discussions about their job expectations and a personal development plan. All satellite sites met the trust's 80% appraisal target: at Mile End 100% staff were appraised, Ealing and Northwick Park achieved 91% and Croydon 81%.
- The trust was committed to advance it's staff and develop their competences with additional training. A number of nurses completed additional competency training such as nurse injection training, prescribing courses, consenting courses, fundus fluorescein angiography or biometry. Most nursing staff also rotated between sites and outpatient clinics which enabled them to gain new skills and experience.
- All staff told us they were happy with the training they received. They told us they had dedicated time for study and felt supported to complete the training. Staff told us study days were well organised, usually on Saturdays, and gave them an opportunity to share experiences with other colleagues. Educators informed senior staff about relevant competency trainings that were happening.
- Staff told us progression was encouraged and there were many opportunities to upskill although at times it took a long time before they were enrolled onto a programme due to high demand.

Good

Are services effective?

- A number of staff told us they completed various internal and external courses and training. For example, a staff member told us they completed an external course for nurses which allowed them to progress from band 6 to band 7. Three nurses told us they obtained post-graduate degrees as part of their personal development plan. A staff member told us they completed clinical ophthalmic practice postgraduate course at UCL. Senior staff told us many nurses completed leadership and mentorship courses.
- Staff told us there was a competency based training and assessment prior to staff doing any new task independently. Staff who completed new competency training were allocated a mentor who supervised them. Senior staff told us nurses updated their competency on a yearly basis and were signed off by a specialist nurse or doctor.
- As part of their induction, nurses who joined MEH had to complete an internal ophthalmic training. All staff we spoke with said the induction was very good. A member of staff who had recently completed the induction programme described it as 'fantastic'.
- There was a local induction checklist for bank and agency staff available on the intranet however we saw this was not always used in accordance with the trust's induction policy. At Mile End there was no formal local induction checklist in place for bank and agency staff, although staff explained they only used MEH bank staff and agency staff were rarely used. Staff told us they only requested ophthalmic trained agency nurses and give them orientation to the department on the first day. Staff at Croydon told us they used the local induction checklist which was stored on-site. Staff said if they had new agency staff they would team them up with an experienced staff member.
- There was a system in place to manage variable staff performance. Senior staff gave us two examples of when they performance managed staff who did not follow correct protocols. The staff in question were supported and their performance was monitored for a period of time to make ensure their practice was safe and within the trust guidelines.

Multi-disciplinary working

- Staff across all groups (medical, nursing, allied health professionals, pharmacy) worked together to ensure patients' needs were met. Internal multidisciplinary (MDT) working was embedded in practice and staff reported good relationships across specialities and gave us examples of when they shared ideas with each other.
- Satellite sites held clinical governance (CG) half days for staff across all disciplines three to six times a year. To allow staff to attend CG half days, all MEH on-site activity stopped. CG half days offered an opportunity for staff to take part in discussions about quality activities.
- Staff from satellite sites attended internal service specific meetings (for example cataract or glaucoma) where complex cases and best practice were discussed. For example, the main specialities (neuro-ophthalmology, orthoptists, stroke physician and occupational therapy) met to discuss how orthoptic stroke service could be improved and more compliant with national standards.
- Apart from the CG and service specific meetings, there were some variations in the internal MDT arrangements across the satellite sites. Croydon and Mile End did not have formal MDT meetings. Ealing and Northwick Park staff had regular meetings where nurses, doctors, pharmacists and Eye Clinic Liaison Officers (ECLOs) shared ideas and discussed issues.
- Patients living with sight loss or partial vision were referred to an ECLO. ECLOs assisted patients by providing information about eye conditions, practical advice, assistance with visual aids and offered emotional support. They also helped patients to register with the local authority for a certificate of visual impairment, sent letters to GP and, when required, contacted social services. Staff told us they would refer any patient to an ECLO if they felt they needed additional support.
- Dedicated pharmacy advisory services for satellite sites was based in City Road. Pharmacists had quarterly link meetings with nurses as well as ad hoc visits and visits in response to incidents and training.
- Some specialist care was only offered at City Road where patients from satellite sites were referred. Staff at Moorfields North told us most consultants had clinics at City Road and to avoid confusion to a patient, consultants would often introduce them to the new team.

Good

Are services effective?

- The safeguarding adults group included representatives from across all sites and key areas within the trust and included clinical and non-clinical staff as well as representation from Islington safeguarding adults partnership board.
- Satellite sites had various external MDT working arrangements. At Croydon staff attended some MDT meetings at the host hospital. For example, they attended some of the dermatology MDTs run when planning a post Mohs surgery (surgery to remove skin cancers) reconstruction. At Mile End staff worked closely with the host hospital's diabetes centre where they regularly referred patients. Staff at all satellite sites worked with district nurses to assist some patients (for example elderly and frail or patients with learning disabilities) to administer eye drops.
- Croydon and Mile End reported good relationships with the local clinical commissioning groups (CCGs) and primary care. At Mile End the clinical director delivered regular talks in ophthalmic care to upskill local GPs. They also provided GPs with a handbook which offers advice on the management of common eye condition which staff was told was helpful and they received positive feedback. Staff at Ealing and Northwick Park said their relationship was less successful. They worried their links with some primary care was not as good and patients were not getting timely access.
- Staff told us they worked closely with local GPs. They informed the patient's GP of their enrolment in clinical trials, every subsequent visit and when patient exited the trial. Also, if a patient was not fit for surgery due to medical reasons (for example high blood glucose) the patient was referred back to their GP to address this before their surgery was rescheduled.

Seven day services

- Satellite sites operated Monday and Friday (Croydon also oneSaturday per month) usually between 7:30am to 6pm. There were no patients nursed in theatre recovery or day surgery overnight at satellite sites. If such arrangements were required, six beds were available for overnight stay at City Road and six beds at St George's. There was an on-call medical rota for City Road and St George's.
- MEH operated a dedicated ophthalmic A&E department at the City Road site, which provided a 24 hour per day, 7 days a week ophthalmic emergency service.
- On discharge patients were provided with a 24 hour support number and information on where and who they could contact out of hours if they had any concerns or experienced possible complications.

Access to information

- Staff had access to information they needed to deliver effective care and treatment. Staff showed us they could easily access information through the intranet and they were confident in doing so.
- The satellite sites use the Moorfields' PAS(electronic patient administration system) and the electronic medical record system, OpenEyes, to book patients, keep medical notes and surgical records. The trust developed an electronic medical record, OpenEyes which includes surgery booking and operation notes recording. There was no interface between the two systems. Some procedures and notes were recorded in the paper based record.
- Patient information was accessible and easy to understand. Notes were well organised for different steps in the patient journey in the surgical pathway.
- Croydon was the only satellite site that was paperless. Other sites used a mixture of paper and electronic records. However, the trust's ambition and long term plan was to have paperless environment at all sites.
- At Croydon the electronic record system was not integrated with the host hospital's system. The host hospital could not access MEH notes of patients moving from theatre to the host hospital's recovery area after general anaesthetic. However, the host hospital staff were provided with a printed copy of the MEH notes which were added to the Croydon paper notes. A copy of the Croydon notes were then copied and scanned into the MEH electronic record. This issue was added to the local risk register and a plan was in place to mitigate any risk.
- Croydon reported a number of incidents in relation to issues with booking patients for surgery which was due to the poor interface between PAS and thetheatre system which was added to the local risk register. At the time of inspection senior staff told us the issue was resolved by the trust's IT team.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The trust had a consent policy and a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards policy

which provided the framework for the care and management of those people who lack capacity. The trust had also developed a mental capacity assessment pocket size prompt card which explained MCA principles, testing for capacity, what best interest was and reminded of the importance of record keeping. Staff told us they found it very helpful.

- A consent form was usually signed at pre-operative assessment or at the time the decision was made for surgery in clinic. The patients were asked to re-consent on the day of surgery. However, some consultants only signed the consent form on the day of the surgery.
- Patients we spoke with confirmed that the procedures were explained to them clearly, including risks and benefits, during the consenting process before their surgery.
- All staff we spoke with were aware of what action to take if they thought patients lacked capacity and needed support. Staff explained that a cognitive assessment was usually done during pre-operative assessment. Senior staff gave us examples of when they held best interest meetings for a person who lacked capacity to make a decision about their treatment. The sites had a contact at the Independent Mental Capacity Advocates (IMCA) to represent a patient who lacked capacity with regard to the relevant decision.
- The trust completed a retrospective audit in regards to the application of the Mental Capacity Act 2005 (MCA) in practice by reviewing patient medical records between January 2014 and January 2015. Results of the audit identified there were significant training needs for staff in regards to the application of the MCA.
- The training completion data showed 61.9% of staff at Croydon and 80% at Moorfields North had completed mandatory training on mental capacity awareness against the trust's target of 30%.
- Senior staff told us clinical trials patients consented twice if their treatment had fallen outside of the trial protocol. All staff involved in clinical trial attended good clinical practice (GPS) training to ensure ethical and scientific quality standards.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We rated caring as good because:

- Feedback from patients and those close to them was very positive. Patients complimented the care they had received and the way staff treated them.
- We saw all staff treated patients with dignity and respect.
- Patients and relatives felt involved in the patient's care and had been given the opportunity to ask questions.
- Emotional support was available to patients.

Compassionate care

- We saw staff were caring and compassionate which was reflected in the many compliments and thank you cards they received. We reviewed some of the thank you cards, for example one stated "Thank you for your excellent expertise in giving me vision of colours and clarity in my R eye after my operation. Amazing".
- We spoke with over 30 patients and their relatives. All patients were very positive about staff and their treatment. Patients told us 'service was quick, efficient and friendly', 'everyone was kind, helpful and calm', 'couldn't be more positive', and 'would give them 10/10'.
- We observed positive interactions between staff and patients. We saw staff were attentive, patients were listened to and their requests were promptly addressed.
- We observed a number of patients during a surgery and saw staff reassured them and clearly explained what was going to happen.
- Many patients we spoke with knew how to make a complaint. A patient told us they would feel comfortable raising a concern or complaint if necessary, however said they had no reason to do so.
- The response rates for the Friends and Family Test between January and March 2016 across the sites ranged from 55.1% and 83.8%. The percentage of patients that would recommend the service ranged from 97.5% to 98.8%. Patients left many positive comments, sometimes naming the staff in their thank you notes. Some comments were 'staff extremely helpful and caring', 'staff were very friendly, and approachable', 'all staff efficient and friendly'. A few negative comments related to the waiting times.
- Results from the post-op survey conducted in June 2015 at Ealing and Mile End, and in September at Croydon were positive although response rates were very low; 19, 4 and 29 responses respectively. All patients but one stated they felt supported and were complementary about the staff. The main suggestion for improvement was the waiting times.

Understanding and involvement of patients and those close to them

- All patients we spoke with were aware and knowledgeable about the procedure they were going to have.
- Patients and relatives told us they felt involved in their care and had been given the opportunity to ask questions. Staff explained that they encourage those close to patients to attend the initial assessment and help make decisions.
- During discharge we observed staff ensured that patients understood the aftercare instructions and this was done in a helpful and pleasant manner.
- During administration of local anaesthetic and during surgery doctors often talked the patients through the procedure and informed them what was happening.
- A number of staff spoke more than one language and were available to interpret for patients who spoke the same language. We saw nurses and doctors speaking with patients in their first language.

Emotional support

- All sites had access to the Eye Clinic Liaison Officers (ECLO) who offered emotional support to patients. Additionally, there was a counselling service available at City Road for patients and relatives at the time of diagnosis, throughout the treatment and during follow-up. The ECLO service offered up to 12 face-to-face sessions.
- Assessments for anxiety and depression were done during the pre-assessment meeting.
- We saw a nurse went with a patient to theatre and held their hand throughout the procedure to offer them reassurance.
- Mile End had a quiet room for relatives. There was no relatives' room available at Ealing and Croydon.

Good

Are services caring?

- Staff who worked across surgery and outpatient clinics said the cross-departmental working gave them the opportunity to follow patients up and patients appreciated this continuity of care.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

Werated responsive asgood because:

- The needs of different people were taken into account when planning and delivering services.
- All senior staff knew who their local population was and understood their needs.
- Patients discharge was planned during pre-operative assessment, where their needs such as transport or adistrict nurse were identified.
- Information provided during discharge was comprehensive with a good explanation of post-operative aftercare.
- MEH used a 'Helping Hand' sticker so that staff could quickly identify patients who needed extra support.
- Patients with a learning disability or those living with dementia were identified at the earliest stage of the referral process.
- Complaints about services were responded towithin the hospital's timescales.

However,

- Croydon, Ealing and Northwick Park's capacity to expand was restricted by the lack of space or access to additional theatres.
- At Mile End food was not routinely offered to patients despite some patients spending over six hours in day surgery.
- The rate of theatre sessions which started late across the satellite sites, apart from Northwick Park, was high.
- MEH sites were not easy to find and there were no easy directions for patients to follow.
- The admission/recovery area at Ealing was small and did not protect patients' dignity and privacy.
- All leaflets were in English.
- The rate of theatre sessions which started late across most satellite sites was high. This was due to delays in identifying list order and doctors arriving late.

Service planning and delivery to meet the needs of local people

- The function of the satellite sites was to deliver MEH ophthalmic care and treatment close to patients' homes. All senior staff we spoke with knew their local population, their ethnic diversity and most common eye conditions and understood their needs. To address population growth, ageing and diversity the satellite sites had been increasing the range of sub-specialties available to the local population so that for most procedures patients did not have to travel to City Road.
- The development planning and accommodation redesign of services at the satellite sites was limited since the sites were located within host accommodation although this was not reported as an issue at Mile End. These limitations were more evident at Croydon, Ealing and Northwick Park where staff explained their capacity was restricted by the lack of space or inability to increase surgical capacity due to host theatre limitations.

Access and flow

- Performance data provided by the trust showed most patients were referred to MEH surgical services by their GP, followed by A&E and external consultants.
- Referral-to-treatment time (RTT) performance standard is that 90% of patients should start consultant-led treatment within 18 weeks of referral. The trust's RTT performance between March 2015 and April 2016 for Northwick Park was 95%. Ealing was 97.1%, Mile End 91.5% and Croydon 84.5%. Staff told us as a tertiary provider the trust often received patients who had been initially referred to other providers and therefore the referral to treatment standard was not always easy to achieve.
- Theatre cancellation rates between March 2015 and April 2016 for Croydon was 6.7%. At Northwick Park the rate was 6.3%, Ealing 5.3%, and Mile End 4.7%, against the trust's target of 6%. The main reasons for cancellations were on medical grounds (patient not fit for the surgery) and patient cancellations. Data showed that all patients were treated within 28 days of their cancellation if this was due to non-clinical reasons.
- Theatre utilisation between November 2015 and January 2016 averaged as follows: Mile End 95.6%, Croydon 77.1%, Ealing 76.8% and Northwick Park 65.4%.
- The rate of theatre sessions which started late across most satellite sites was high. Performance data provided by the trust showed that between March 2015 and April 2016 at Croydon 67.5% of theatre sessions started late.

At Ealing it was 50.2% and at Mile End 17.9%, against the trust's target of 15%. Northwick Park achieved the trust's target with 10.6%. Amongst reasons for the delays were identifying the lists order and anaesthetists or surgeons arriving late.

- The percentage of ophthalmology surgery performed as day case surgery between March 2015 and April 2014 was 99.8% against the trust's target of 90%.
- Pre-operative assessment was carried out near the surgery date. During the pre-assessment meeting staff discussed and planned discharge arrangements with the patient or their carer. They discussed transport needs, the patient's ability to self-care (for example, administration of drops, medications and dressing change) and requirement for district nursing support.
- Adult patients who had their surgery under general anaesthetic (GA) at Ealing are recovered in the host Trust recovery area and then returned to the Moorfields day care unit where they are cared for by Moorfields trained staff. At Croydon adult patients go to the host Trust recovery area and then to the host Trust day surgery area for discharge. Northwick Park and Mile End patients who required procedures under GA or with pacemaker were referred to City Road.
- Patients presenting to one of the satellites with eye problems requiring urgent attention were transferred to City Road for further management. However, if a consultant at the satellite site felt they had the resources to treat such patients adequately, they had the discretion to do so. Patients presenting to Croydon with an eye problem requiring urgent attention were managed locally through the urgent care service. However, if a consultant at the site felt that they did not have the resources to treat the patient they would arrange to transfer the patient to St George's or City Road.
- The sites usually run morning and afternoon theatre lists and all patients were typically admitted at the same time. Staff told us this was done for practical reasons as surgeons carried out all pre-operative assessment first and then decided on the patient list order. However, since there was no appointment system in place this led to some patients having to wait a long time for their theatre slot. During our visit we saw patients who waited three to four hours for their surgery.
- Most children were referred to MEH at Croydon by the A&E of the host hospital, local GPs or optometrists. In hours, children were seen by MEH ophthalmologists in the eye clinic with consultant and orthoptic support. Out of hours children were referred to MEH at St George's which runs a24/7 service. There was inpatient paediatric surgery at Croydon, although most procedures were day surgeries. After a procedure children were admitted to a dedicated paediatric day care ward at the host hospital.
- Patients were given a follow-up appointment prior to discharge and the appointment was booked at the same satellite site or nearer the patient's home.
- Following all consultations and surgery a letter was sent to patients' local GP. A GP discharge letter was also given to the patient. Staff told us they had established links with local GP surgeries and district nurses which were necessary to organise post-operative care in the community. However, staff at Ealing and Northwick Park told us links with some GPs were not that efficient.
- Patients told us they were happy with the discharge information they were provided, which was explained clearly and they knew what to do if they had any concerns. We observed patients being discharged and we found the process to be comprehensive, with good explanations of post-operative aftercare. Staff told patients about signs and symptoms to look out for and gave them day time and out of hours emergency contact numbers. Patients were also given leaflets on aftercare, the medication they needed to take and advice about general activities of living.

Environment

- At Ealing, patients were admitted and discharged in the same room. The room was small and could accommodate two patients at the same time. Patients were separated by a screen that was not wide and long enough to protect their dignity or allow private conversations. There was no separate area if a patient needed to speak in private, except for the consultation room when it was not in use.
- The waiting area at Ealing was shared with the host hospital's day ward. Patients in the waiting area could see and hear what was happening in the admission/ recovery lounge.
- Since the waiting area was small and shared with another ward, there was a risk of overcrowding. The risk was added to the local risk register and one of the control measures was to stagger appointments to avoid admitting all patients at the same time. Also, only one relative was allowed with each patient to avoid

overcrowding. However, on the day of our visit we saw this was not the case and patients were given the same arrival time. Staff confirmed staggering was not happening. Although the area was not overcrowded, we also saw a patient who arrived with three relatives.

- The consultation room at Ealing was very small and staff struggled to accommodate wheelchair users. Staff told us at times it was stressful, especially if patients were accompanied by their relative or carer. However, the trust commented that there was an alternative space which could be used within the Moorfields day care area when space was limited.
- At Ealing the nearest patient toilets (male, female and disabled) to the day care area were close by in the neighbouring ward that belonged to the host hospital. Staff were aware of them and were asked to assist patients if they were on their own.
- As Northwick Park did not carry out procedures under general anaesthetic, the recovery room was utilised as a storage room. A number of staff reported a lack of space at Northwick Park and Ealing sites.
- MEH sites were not easy to find and there were no easy directions for patients to follow, for example reasonable adjustments for visually impaired patients. At Mile End and Croydon staff told us a porter or volunteer from the host hospital directed or brought patients to the ward. However, we did not see such an arrangement at Ealing. MEH at Ealing was difficult to find despite MEH signage being on yellow rather than blue background which distinguished them from the host hospital's signage. Staff explained that they did not have complaints from patients about difficulties in finding the place, however all but one patient we spoke with on the day told us the day surgery was not easy to find.

Meeting people's individual needs

- Most staff had large yellow badges stating their name and they were clearly visible for all to read.
- Discharge letters, documents and many leaflets were printed in a large font. Leaflets were also available in braille.
- During a pre-assessment clinic, information about patients' individual needs were recorded. A matron or day care senior staff booked extra staff for the day of surgery to care for these patients according to their needs.
- Staff told us patients with learning disabilities or dementia usually came with their carers and they always tried to involve them in the discussions regarding the procedure and post-operative care.
- The trust used a 'helping hand' sticker which was put on patient's notes to help staff quickly identify anyone who needed additional help, for example patients with learning difficulties, dementia, and patients with mobility or hearing problems. There was a separate sticker if someone required transport. All staff we spoke with knew about the 'helping hand' stickers. Additionally, administrators who arranged appointments informed the matron or nurse in charge of day care about appointments for patients with learning disabilities.
- Staff told us that when deciding the order of the theatre list they tried to prioritise patients with dementia, learning disabilities or mental health issues, patients who had prior transport arrangements, who were in pain or anyone whose condition would deteriorate due to a prolonged wait.
- Patients who had learning disabilities were able to be accompanied to the anaesthetic room by their carer if this was required to calm and reassure them. We saw an example of when a relative was allowed into the anaesthetic room to comfort a patient.
- Staff worked with the liaison nurses to make reasonable adjustments. At Croydon staff liaised with the host hospital's specialist liaison nurse to support patients with learning disabilities.
- All sites used hospital passports for patients with learning difficulties, and the 'This is me' booklet for those living with dementia. Croydon did not use MEH passport as they were paperless but local patients had the host hospital's passports.
- The trust explained that they had easy read leaflets for patients with learning disabilities which staff could produce when needed. These included information on diabetes conditions and screening, cataract, choosing glasses, clinic feedback forms, the Patient Advice and Liaison Service (PALS) and complaints procedures, and day care surgery visits, amongst others. However, none of the staff members we spoke with mentioned the leaflets when discussing support for patients with learning disabilities.
- Eye Clinic Liaison Officers (ECLO) were available across all sites to offer emotional and practical support to patients. There was one ECLO who covered the Ealing

and Northwick Park sites and one who covered all East London satellite clinics. At the time of the inspection the ECLO from Croydon had left and the site was using an ECLO from City Road but senior staff explained they were in the process of recruiting a new one. In the interim, optometrists were supporting low vision aid work.

- Croydon had an established relationship with the International Glaucoma Association (IGA) and a volunteer was available in the clinical setting to offer help and support to patients. Clinical staff did presentations at glaucoma days organised by the IGA.
- Interpreting and translation services provided by the sites included face-to-face language interpreters (available if booked in advance of the appointment), telephone interpreting services (available on-the-day) and British sign language interpreters (available if booked in advance of the appointment). However, at Ealing the telephone interpreting service was not available.
- A senior staff member told us the language barrier meant the population was less likely to present for medical attention at early stages. However, we saw little evidence this was being addressed despite the large non-English speaking demographic around the satellite site areas.
- Staff explained that need for translation services was identified during initial assessment or through a referral letter. A number of staff members including doctors and nurses, could speak different languages. At Ealing one of the secretaries was regularly asked to translate and interpretation became part of their role. Staff explained that if patient insisted, they used a relative to translate but this was not favoured. However, some staff members told us this principle was not always followed. During pre-operative assessment some patients were asked to bring a relative to assist with translation. A staff member told us if a patient could not understand they were asked to call someone who could speak English. We also observed two patients waiting for a procedure who spoke little or no English with a family member accompanying them to interpret. One of the patients who came with a relative told us they were not offered an interpreter. We also observed a patient's relative was allowed in the operating theatre to translate.
- Leaflets were readily available in English and staff would contact the Trust PALS department to get translated leaflets. The trust website also contained information about eye conditions and there was an option to translate the information into different languages.
- There was no arrangement for food at Mile End. Staff told us that if a patient was diabetic they offered them biscuits or they could arrange for a sandwich. The senior nurse was talks with the catering department to have a small selection of sandwiches available.
- Each site had an onsite cafeteria where patients could purchase food. Croydon had a variety of options including a small supermarket.
- Patients we spoke with commented about long waiting times and that they all had been given the same arrival time. Some patients were not aware of how many surgeons were operating or how many people were in front of them. They stated it would be helpful to have an estimate of how long they would be waiting and said they would like more communication.

Learning from complaints and concerns

- Patients told us they knew how to raise a concern. Complaints forms were available and the Patient Advice and Liaison Service (PALS) was advertised in all patients waiting areas. We saw leaflets available at each location informing patients and relatives about the complaints process. These were only in English, however the trust informed us versions in alternative languages were available on request.
- Staff across sites told us they did not receive many complaints and most of them were verbally resolved and rectified at the time the complaint was made. If a patient wanted to make a formal complaint staff would support them by explaining the complaint processes.
- Data provided by the trust between March 2015 and April 2016 showed Mile End received one formal complaint, Croydon six and Ealing seven. The average response time across the three sites was 10-12 days with all sites meeting the trust's 25 days target.
- We reviewed six responses to complaints all of which contained an apology, thanked the complainant for bringing the matter to the trust's attention, offered contact details for further assistance and enclosed information on how to proceed if the person remained dissatisfied.
- Staff told us that complaints and the learning were discussed at CG and surgical services directorate

Good

Are services responsive to people's needs?

meetings. Meeting minutes showed complaints were regularly discussed during the two meetings. During a weekly serious incident meeting at City Road complaints that required a multi-disciplinary discussion were discussed.

- A six monthly complaints handling survey was carried out every alternate six months. Complainants were contacted two to four weeks after they had received their final response and asked about the way their complaint was handled both by local staff and by the complaints team, how honest they felt the response was and if they felt all their concerns had been addressed. Complainants who had raised clinical issues about their treatment or care were telephoned two weeks following their final receipt to discuss the response and to offer further support.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated well led as good because:

- There was a good governance and risk management structure in place.
- The trust values, 'the Moorfields Way', were developed in consultation with staff to help staff focus on what matters for patient care.
- All staff attended clinical governance half days where they learned about audit results, clinical outcomes, incidents, complaints and patient feedback.
- Nearly all staff morale across all sites was good.
- Staff were proud to work at MEH and would recommend it as a place to work.
- Nearly all staff said they had many opportunities to progress and development was encouraged.
- Staff frequently contributed to and influenced national and international guidelines and practice.

However,

- Patients complained about long waiting time for their procedure on the day of the surgery. The trust was aware of this concern and tried to mitigate it. However, during our visit we saw that this was still a major issue. One of the contributing factors was delays in theatre lists due to doctors arriving late.

Vision and strategy for this service

- Moorfields North and Croydon strategy and vision was in line with the trust one. The vision was to continue to provide a comprehensive range of eye care services operating through a network of centres that were linked to City Road. The surgical directorate strived to deliver the highest standards of care, patient experience, outcomes and safety across all sites. Staff told us satellite sites were able to offer a patient centred approach and abetter patient experience that was closer to patients' homes.
- Mile End sought to maximise the use of the existing site in the short-term to meet the increased demand and help meet the capacity gap. Their plan was to provide more of the sub-specialist activity in particular corneal, medical retina and paediatrics. In the longer term, the strategy was likely to focus on developing a district east hub for the area. Senior staff told us there was a risk of overexpansion by diluting services which could lead to a drop in the standard and quality of care. They stated that they would consider each opportunity in detail to evade that risk.
- At Ealing the longer term future of the site was unclear and depended on the host hospital site. The existing accommodation was not ideal with theatres being far from the outpatient area and there were general space constraints. Staff told us the unknown future of the site was concerning and that Ealing did not have a clear vision.
- Croydon had a clearly defined business plan for their service to meet the trust's vision. The objective was to expand capacity, improve outcomes and patient experience.
- The trust values, 'the Moorfields Way' were developed in consultation with staff to help staff focus on what matters for patient care. We saw the values were displayed in the day care areas and clinical rooms. Staff were able to articulate these to us and showed understanding of the values. Staff gave us an example of when 'the Moorfields Way' was used to address specific staff behaviour and attitude in their practice. A staff member told us the Moorfields Way was good initiative and reminded them of their responsibilities towards patients and colleagues.

Governance, risk management and quality measurement

- Site specific clinical governance (CG) half days meetings were held approximately every quarter. All clinical activity (apart from emergency) was stopped to allow staff to attend the meeting. The meetings aimed to ensure quality and safety was at the forefront for all staff. CG half days provided a forum for presentations and discussion around the quality of MEH activities. The standing agenda items included topics such as audit results and actions, clinical outcomes, complaints and patient feedbacks and incidents. The meetings were

Good

Are services well-led?

minuted and fed back to the trust's quality team. We reviewed a sample of meeting minutes from CG half days and found them to have well-structured agendas and to be comprehensive.

- Service specific CG half days were usually held every two months. There were a regular agenda items such as incidents, complaints and claims, clinical audit presentations, quality and safety. The meeting offered a forum where issues were discussed and staff were encouraged to suggest solutions.
- Monthly balance scorecards for surgical services were discussed at the surgical services directorate monthly review meetings. The scorecards covered different aspects of care in terms of performance and quality.
- We saw that never events (NE) were discussed at different CG half days. Although all senior staff we spoke with knew about the most recent NE some band 5 and 6 staff were not aware of it despite staff informing us that they attended CG meetings or received the meeting minutes. Also, some staff did not know what a never event was. A senior staff member explained that sometimes dissemination of information was a challenge as email was overused.
- There were clear processes for escalating and cascading information. Clinical directors fed back information to trust management board, while the medical director passed any information back to the clinical directors. Clinical directors forwarded any relevant information back to their teams.
- Each site had a risk register which was locally managed.

Leadership of this service

- Staff across all sites told us the new CEO had visited their site in the recent weeks. Staff told us the director of nursing and medical director were supportive and visible.
- Senior level management understand their service and challenges to good quality care.
- Staff morale across all sites was good. Most staff felt supported by the senior level management who were described as approachable, supportive and encouraging. Senior level managers told us they were very proud of their staff and happy they could develop them. Most staff felt involved in making decisions.
- Although the trust told us there was a dedicated HR business partner and HR manager who spend dedicated time at Croydon, staff reported limited support from the trust particularly with recent staffing issues.
- Staff across sites told us they often finished late and although they could claim their time back, sometimes they did not have the time to take it.
- Long waiting times during the day of surgery was the main complaint theme in the Friends and Family Test and post-op survey. This was also highlighted by staff and patients during Moorfields Way focus groups and by Healthwatch. Staff we spoke with told us waiting times were a challenge. They tried to manage patients by explaining to them why they waited and by keeping them company. The trust was aware of the issue. The June 2015 the patient experience annual report highlighted some initiatives undertaken to reduce waiting times and improve patents' experience. However, during our visit we saw that this was still an issue.

Culture

- Most staff told us they were proud to work at MEH which they said had a good reputation and they would recommend as a place to work. A staff member said it was a 'special place to work' while another told us the work was interesting and challenging. Staff told us they 'loved' working at MEH. Many staff had worked at MEH for a long time or had left and returned. Another staff member told us he 'would be happy for his relative to be treated here'.
- Staff said they had many opportunities to progress and development was encouraged. They said there were equal opportunities for everyone to apply and attend courses. Only one staff member said that although training was available, there were not always equal career progression opportunities.
- Staff told us the trust organised a session on life planning for over 50s which they thought was very good and useful.
- All doctors and nurses spoke highly of each other and reported a very good working relationship and team work. Medical staff said the nursing staff was committed, they 'felt lucky to have such skilled team' and appreciate their hard work. Nursing staff said they felt valued and supported and told us doctors were approachable and always happy to help and teach. Nursing staff felt confident to challenge doctors and gave us two examples of when they did, for which they were thanked.

Good

Are services well-led?

- We found the culture was open and honest. Staff gave us an example of when they apologised to patients when they made an error. Staff told us that when reporting incidents they felt supported by their managers and there was no blame culture.
- Nearly all staff reported they did not experience or witness cases of bullying or harassment. One staff member told us they experienced harassment from their manager but they did not feel comfortable to report problems as they felt they would be blamed.
- The trust told us that in response to a number of issues, including bullying and harassment, identified in the staff survey two and a-half years before, the trust established the Moorfields Way initiative. Within this, there were mechanisms, including trust-wide and local action plans, to address issues from the staff survey. These action plans included focus groups run by independent consultants, presentations on the Moorfields Way commitments and behaviours in team meetings and development and coaching for managers in areas with the poorest survey results. Progress was measured through the staff Friends and Family Test, with 95% of respondents in March 2016 saying they had heard of The Moorfields Way and 33% saying it was making a difference.

Public and staffengagement

- Every three months a survey was sent to all patients who underwent surgery at MEH to ask questions around the patient experience and customer service.
- Patients' feedback was collected through the Friends and Family Test (FFT).
- Mile End staff organised patient days, such as a glaucoma day once a year. Croydon worked closely with the IGA volunteer who organised glaucoma days for patients.
- The trust carried out a survey to improve patients' experience of their anaesthesia. One hundred patients were surveyed and based on their responses, the information leaflets were improved to the management of patients' anxiety.
- The trust consulted Royal National Institute of Blind People (RNIB) to look at the most optimal reading contrast.
- As a result of poor staff attitude being identified as a theme in complaints, the Moorfields Way was established. The objective of the Moorfields Way was to identify and promote behaviours patients and staff would like to see in MEH staff.
- At satellite sites staff attended regular team meetings where they could discuss any issues and give feedback.

Innovation, improvement and sustainability

- The trust created infographic posters of policies and half- to one-page policy summaries to improve staff retention of information. We saw a few examples of such posters which were displayed in staff areas.
- Mile End and Croydon introduced virtual clinics to shorten the patient pathway and improve patient experience.
- Nursing staff were upskilled to advance their role, for example MEH introduced a nurse-delivered intravitreal injection service, a building protocol and a developing training programme for it.
- A staff member introduced the idea of a Helping Hand sticker to help staff quickly identify patients who required extra support.
- We spoke with a number of staff who regularly contributed to national and international conferences, for example a staff member told us about a recent international conference where they presented on improving patients' experience.
- A number of staff were specialist advisers to National Institute for Health and Care Excellence (NICE) and regularly contributed to Royal College of Ophthalmologists (RCO) guidelines. Staff contributed to and influenced national and international guidelines and practice, for example on cataract surgery, refractive surgery standards, diabetic retinopathy, retinal vein occlusion and provision of ophthalmic anaesthesia.
- Two members of staff were appointed as clinical leads for the ophthalmology element of the Getting it Right First Time (GIRFT) programme which aims to improve quality of care, patient experience, enhance safety and ensure cost effectiveness.
- Staff said the trust was generally supportive of innovation although at times slow to make decisions on pilot schemes. A staff member said there was room for research and innovation and gave us an example of a recent idea they were looking to introduce to meet the needs of satellite sites.