

Spamedica - Citygate


Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spamedica Citygate, Manchester is operated by Spamedica Ltd. The site opened in 2008 providing cataract surgery and YAG laser treatment services to the NHS and was the first hospital site to open for the provider. It is located close to the city centre and is accessible by car and public transport. The service provides cataract surgery and age-related macular degeneration (AMD) injections for adults referred from the NHS.

We inspected this service using our comprehensive inspection methodology. We carried out this unannounced inspection on 25 October 2019.

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

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

We rated it as **Good** overall.

We found good practice in relation to surgery:

The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Staff worked especially hard to make the patient experience as pleasant as possible.

The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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

Ann Ford
Deputy Chief Inspector of Hospitals

Overall summary

Summary of findings

The service is registered to provide the following regulated activities:

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

During the inspection, we visited outpatient and surgical areas. We spoke with 15 staff including registered nurses, health care technicians, reception staff, medical staff, and senior managers. We spoke with eight patients and six relatives. During our inspection, we reviewed five sets of patient records that covered cataract surgery, age-related macular degeneration (AMD) and YAG laser.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This service had been inspected following previous methodology.

Activity (July 2018 to June 2019)

- In the reporting period July 2018 to June 2019 there were 3 702 visits in the operating theatre
- There were 6 239 day case episodes of care recorded at the Hospital.
- There were 6 863 outpatient total attendances in the reporting period.
- All patients were NHS-funded.

There were a total of 17 surgeons who worked for the provider under practising privileges. Of these, seven had carried out between 10 and 99 episodes of care and 10 had carried out more than 100 episodes of care. There was one regular surgeon who worked at the location. The

service employed 10 registered nurses, seven health care technicians, eight patient co-ordinators, as well as having its own bank staff. These were shared with another location that was buddied with them.

Track record on safety

- There were no never events
- There were a total of 40 clinical incidents of which 38 were classified as either no harm or low harm
- Two incidents were classified as moderate harm
- There were no serious injuries

There were no incidences of hospital acquired Meticillin-resistant *Staphylococcus aureus* (MRSA),

There were no incidences of hospital acquired Meticillin-sensitive *staphylococcus aureus* (MSSA)

There were no incidences of hospital acquired *Clostridium difficile* (C.diff)

There were no incidences of hospital acquired E-Coli

There were 6 complaints

Services provided at the hospital under service level agreement:

- Sterilisation
- Decontamination
- Out of hours call handlers
- Pathology
- Interpreter services
- Cleaning
- Clinical waste
- Confidential waste
- Pharmacy service

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating

Good



Summary of each main service

We rated this service as good because it was safe, caring, responsive and well-led and outstanding in effective.

Summary of findings

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Good



Spamedica - Citygate

Services we looked at

Surgery

Summary of this inspection

Background to Spamedica - Citygate

Spamedica Citygate, Manchester is operated by Spamedica Ltd. The service opened in 2008 and was the first location for this provider. It is a private hospital in Manchester. The hospital primarily serves the communities of the Manchester area. It also accepts patient referrals from outside this area.

The hospital has had the current registered manager in post since October 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a second CQC inspector. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Good



Are services effective?

Are services effective?

We rated it as **Outstanding** because:

Outstanding



Summary of this inspection

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. Outcomes for people who use services were significantly better than expected when compared with other similar services nationally.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Are services caring?

We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Good



Are services responsive?

Are services responsive?

We rated it as **Good** because:

Good



Summary of this inspection

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Are services well-led?

We rated it as **Good** because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and

Good








Summary of this inspection

issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Surgery

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

Are surgery services safe?

Good 

We rated it as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff completed annual mandatory training. This was a combination of face to face training and online e learning.

The regional manager had completed advanced life support training. All registered nurses completed immediate life support (ILS) training and all of the healthcare technicians and patient co-ordinators completed basic life support (BLS). The lead optometrist, who was the laser protection supervisor had completed ILS.

There were new starters; a registered nurse and a health care technician who were booked onto training as part of their induction process.

All staff had completed e learning modules as part of mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff completed safeguarding training level one annually and level two for adults and children every three years.

The hospital manager had completed level three safeguarding training for adults.

There was a nominated lead for safeguarding for the provider who was booked to complete level four training later in the year.

There were safeguarding policies in place as well as a NHS safeguarding desktop application on all hospital computers for reference with local contact numbers.

The safeguarding policy for children, we reviewed, referenced the intercollegiate guidance 2014 rather than the updated 2019 and did not include reference to working together to safeguard children (2018).

In the twelve months prior to inspection, there had been no safeguarding referrals made.

Safeguarding information was displayed in all clinical rooms for staff to access.

Staff we spoke with were aware of their roles and responsibilities in safeguarding and knew how to raise matters of concern appropriately.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

There was no meticillin-resistant *Staphylococcus aureus* methicillin-sensitive *Staphylococcus aureus*, *Clostridium difficile* or *Escherichia coli* reported by the service between May 2018 and April 2019.

Surgery

All areas visited were visibly clean and free from clutter.

Personal protective equipment was readily available and included gloves. Appropriate theatre attire was available for surgical procedures. Soap dispensers included 'hand sanitizing techniques' and posters of 'bare below the elbows' were displayed throughout the service.

Wall-mounted hand gel sanitizers were readily available in all areas that included patient rooms. Staff we observed used sanitizing hand gels before providing patient care. All staff we observed adhered to the 'arms bare below the elbows' policy in clinical areas

Sharps bins were present, in clinical areas. These were dated and all were secure and not over filled.

There were nominated infection control link staff members who had received additional training.

The provider was recruiting for a national lead for infection prevention and control and had secured an agreement with a consultant microbiologist lead for expert advice and guidance.

Infection control audits were carried out with a recently increased compliance standard of 90%. If compliance was below, a re-audit was carried out the following month. In March 2019, there was a compliance of 100% overall and in September 2019 compliance was 98%. Quarterly hand hygiene audits had compliance scores of 93% in March 2019, 100% in June 2019 and 95% in September 2019.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service was on the ground floor of a tower block.

Fire instructions and equipment were available with exits clearly marked.

Access to some clinical areas was restricted to staff only requiring swipe card access, however; we observed that the theatre suite doors were not locked and this was close to a patient waiting area. We addressed this on site. We were told that they were in the process of introducing a swipe card access system. This included changing access for rooms currently entered by a key pad system.

There were resuscitation trollies close to the outpatient area and the theatre area. We reviewed one of the trollies and found that daily checks of the top of the trolley had been completed with a weekly check of the trolley contents. The contents were sealed with tamper proof tags. We noted the checklist, in use, did not reflect all the contents, however; a previous version was in place accidentally. This was replaced on-site. Audits for the resuscitation trolley were carried out quarterly. There was 100% compliance in March 2019, June 2019 and September 2019.

In each room, environmental temperature was checked and recorded daily along with daily check lists for each room. These had been completed in each room visited.

There was one operating theatre and outpatient areas for pre and post treatments.

Clinic room audits were carried out quarterly. For March 2019, the compliance was 92% and for June 2019 and September 2019 the compliance was 100%.

In the examination room, a slit lamp was available for adhoc examinations as required by surgeon.

The laser provided was a YAG laser, to treat posterior and anterior capsular opacification. The laser protection advisor (LPA) was accessible via phone or email should staff need advice and there was a service level agreement in place to support this provision. All staff attended a core of knowledge course with the laser protection advisor who provided the appropriate level for the laser protection supervisor. There were local rules that all staff were expected to read and understand; these were updated wherever there was a change to equipment, staff using the equipment or the LPS. There was a two yearly risk assessment/audit conducted by the LPA, where an action plan was completed for any recommendations/issues raised.

Assessing and responding to patient risk

A multi-disciplinary huddle was held each morning in the hospital to plan and review the day's activities.

Risk assessments were carried out for patients including falls, mobility, dementia and anxiety. Patients were assessed to check if could tolerate lying flat during the procedure.

Surgery

There was a health and safety policy, however; this was past the review date in 2018. The service was reviewing all policies at time of inspection.

There was an exclusion criteria for the location that was aligned to commissioning requirements. Each patient was assessed for suitability on an individual basis. If necessary, patients GP or hospital consultant would be contacted for additional information with the services medical director assessing if the patient was suitable to be treated at the service.

There were organisational care pathways that were individualised for each patient. There were clear sections that highlighted any variances to be aware of. Any allergies were clearly highlighted.

The service did not provide general anaesthetics or have patients staying overnight.

There were standardised emergency endophthalmitis kits available at the hospital if needed. These kits included treatments for initial management of both bacterial and endophthalmitis which a severe inflammation of the tissues inside the eye is due to infection.

Patients at high risk of posterior capsule rupture are placed on specialist complex lists, at a neighbouring location, where there was a vitreoretinal surgeon, longer operating time slots and the ability to undertake complex vitreoretinal surgery if required.

The service carried out routine tests during the pre-assessment process. Each patient had a biometry performed. These images take multiple measurements from the eye to calculate the power of the lens that will be implanted during the cataract operation. Ocular coherent topography(OCT) scans were performed on any patient who presented or had previously had any retinal pathology. These scans helped assess a patients suitability for cataract surgery at the service.

The A-scan test measured the length of the patients eye to determine the lens selection for patients with dense cataracts.

Epithelial cell count (ECC) was performed before surgery for patients who were at higher risk of developing corneal issues post operatively.

Patients that presented with corneal problems pre operatively had a corneal topography map to assist with prognosis.

All patients had a detailed eye examination pre-operatively. The images produced could identify other eye related disease for diagnosis.

Clinical suite:

In the diagnostic room health care technicians performed required diagnostic tests.

In the two visual acuity rooms, this was tested along with testing of intra-ocular pressure test and dilatation of the eye by a health care technician.

In the two pre-assessment rooms a registered nurse took full medical history including any prescribed medicines and known allergies. Blood pressure was taken along with blood glucose (if appropriate). The patient was provided with verbal and written information of what to expect.

For the two optometrist rooms, an optometrist completed a slit lamp examination, if appropriate for surgery and written consent was obtained. A full explanation was provided of what to expect and then escorted to reception to agree a surgery date.

Surgical suite:

In the pre-admission room a registered nurse completed the admission process. The eye was dilated, with drops, in preparation for surgery. Vital signs including blood glucose, if necessary was checked and pre-assessment details reviewed. Consent and any diagnostic tests were checked as well as applying an identification band and allergy band, if appropriate. The surgical site was then marked.

In the surgical ward there were five chairs (two reclining and three standard). This was a pre-treatment holding area for the patients prior to surgery.

In the pre-theatre room, a health care technician removed the eye dilator. The patients identification, consent and diagnostic tests were checked and made available for the surgeon. The surgeon introduced themselves to the patient and checked the consent and diagnostic tests in addition to choosing the appropriate lens.

In the operating theatre, the planned cataract surgery was performed under topical anaesthetic.

Surgery

In the discharge room, a registered nurse provided the patient with discharge information and guidance (verbally and in writing). Blood pressure was checked and patient feedback obtained specifically on bedside manner and patient experience in theatre.

Cataract lists were populated with routine cataract extraction and intra-ocular lens implanted in addition to vitreoretinal surgery. There could be up to 25 patients on each list. The theatre team took a lunch break after the morning list which was usually patient number 14.

The provider used an adapted version of the World Health Organisations cataract five steps to safer cataract surgery checklist. This checklist is used to ensure safety and help reduce any errors during the surgery.

On the day of inspection, the theatre was in use for age-related macular degeneration (AMD) injection procedures. We observed two patients and saw that the checklists for this procedure had been completed appropriately. We did note that the checklist was headed cataracts. This was addressed on-site.

Audits of the checklist showed 100% compliance in June 2019 and September 2019.

Each treatment room had a phone that had a tannoy facility. In the event of an emergency, a call could be made to alert other staff at the location.

In the reporting period, there had been no transfers to a neighbouring NHS hospital. There was no formal service level agreement in place; the service would call 999 if needed.

There was a resuscitation policy that was within the review date.

An arrest simulation was carried out in August 2019 with staff responding well in the scenario.

Registered nurses completed immediate life support training; health care technicians and non-clinical staff completed basic life support training.

In audits of the theatre trolley emergency drawer there was 100% compliance in June 2019 and September 2019.

Audits of the glucometer (to measure sugar in the blood) showed compliance of 97% in March 2019 and 94% in September 2019.

Surgeons and optometrists supported the 24 hours a day, seven days a week out of hours clinical service providing patients with emergency call out service in the event of a complication. The optometrist triaged calls and gave advice. If there was a medical/surgical query which they were unsure of they sought further advice from the specialist doctor or consultant on call. If it was deemed appropriate for the patient to be brought in for urgent assessment, then the consultant and registered nurse on call were contacted, the hospital was opened and the patient was met at the hospital site.

Nursing and support staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency staff a full induction.

Hospital managers liaised across the region to support and plan staffing. Patient activity was shared in advance to hospital sites to enable forward planning of off duty.

The organisation ensured that the staffing team had appropriate skills and if considered that a team required additional resources due to the potential complexities of the service or skill-mix of team members, staffing was increased to ensure that the clinical staff were suitably supported.

Team members were only considered 'in numbers' once they were deemed competent to ensure clinical quality and patient care was of the highest standard.

There were agreed minimum headcounts for the clinics and clinics only proceed when the standard of skill-mix is confirmed. As a minimum requirement:

-Theatre= one ophthalmic surgeon, two registered nurses, two scrub nurses and two health care technicians.

-Pre-Assessment Clinic (PAC)= One optometrist, one registered nurse and two health care technicians.

-Post operative clinic (POC) = One optometrist, one registered nurse and two health care technicians.

-Age related macular degeneration clinic (AMD) – Two registered nurses and three health care technicians.

Surgery

There was a total of 25 staff employed at the hospital including registered nurses and health care technicians as well as support staff.

From July 2018 to June 2019, there was an average of 18.8% registered nurse bank / agency staff employed per month in theatre. Any new agency staff were required to complete an induction and have competencies signed off before providing any patient care or treatment.

The average sickness rate, for the same period, across all staff was on average 0.1% per month.

There were two optometrists who supported the ophthalmologist.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

All ophthalmic surgeons and optometrists were reviewed by the medical director to ensure the appropriate practising privileges were completed and in place.

For the reporting period of July 2018 to June 2019, there were 17 doctors employed via a practising privileges arrangement. Of these six had carried out between 10 and 99 episodes of care and 11 had carried out 100 or more episodes of care.

There was one ophthalmologist that carried out this service via a practising privileges arrangement.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

In the three months prior to inspection, 100% of records were available for appointments.

Patient records were a combination of paper and electronic. The electronic record included pre-assessment details, theatre, discharge and post-operative care. There was a paper record that included consent, demographics, copy of biometry, outcome forms and referrals. All scans could be viewed electronically although hard copies could also be reprinted in clinic.

In the event of a misplaced medical record, the patient would be re-consented on the day of surgery and diagnostics and referrals could be re-printed. Any misplaced or missing patient record incidents would be logged on to the providers reporting system and an investigation commenced.

There was a business continuity plan in place to safeguard records should there be any electronic or power outages.

Records were stored securely in the reception area, transferred to locked area at end of day. At the end of treatment, records were couriered back to headquarters for archiving.

Monitors could only be viewed by reception staff.

Records followed patients and stayed in rooms with staff.

We reviewed records for five patients and found they had been completed appropriately.

Records audits completed in March 2019 and June 2019 showed a compliance of 89%. Areas of non-compliance included dating of the WHO checklist and printing name. Extra training had been organised to support staff to complete all sections.

Confidential waste was placed in shredding bins and removed by an external company via a service level agreement.

Medical records are only ever removed from site in secure locked transport carriage boxes at pre-arranged times by our internal transport service. The recipient confirmed receipt of the patient record when it arrived by signing the file transfer form at the required hospital location. Records did not remain in vehicles overnight. Each transferred patient record was recorded by completing a file transfer form. Only staff with agreed access to patient records had the authority to transfer a patient record. All paper records of discharged patients were scanned and indexed to be retrieved on request for planned follow up appointments. All clinical diagnoses and episodes of treatment records were stored electronically and were available at all sites in the case of an unplanned follow up.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Surgery

The service used topical and local anaesthesia to the eye only. Drops were prescribed using patient specific directions (PSD). These were administered by health care technicians who had completed competencies. They recorded that the drops were given on the paper PSD and also in the patients electronic record. We observed that the paper record was either ticked or abbreviations used to indicate given. We addressed this on-site and were told that after the inspection, staff were reminded to include full signatures.

The medicines management policy referred to patient group directions and PSD's. A patient group direction (PGD) is a written instruction that includes the administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The service had plans to introduce PGD's following consultations with commissioners.

The medicines we sampled were all within their expiry dates.

The service stored diazepam to be available for patients who were identified as anxious prior to surgery. It was stored appropriately and records completed for checking and administration. The prescribing of diazepam was included on the prescription chart with other medicines given following PSD's. We observed that the controlled drug book included an entry for a medicine not present (not controlled) dated 2014. We addressed this on-site.

We observed that a checklist prior to the AMD injection included a written dose of medicine different to the actual dose. This was addressed immediately on-site. The sheet was changed and the other location that carried out this procedure was shared the information to use the revised form.

We reviewed medicines errors that had occurred and were told that there had been some re-training for individuals identified.

The temperature of the clinical fridges were monitored. The service identified an issue with the recording of the range with the maximum being raised. This had resulted in the disposal of medicines and quarantine of others. An action plan had been created that including the re training of staff to ensure clear about recording and re-setting of probes. A system of adding red dots to medicines close to their expiry date had been introduced and a tracking system was being developed.

Fridge temperature audits showed compliance of 90% in March 2019, 100% in June 2019 and 93% in September 2019.

Audits of take home medicines showed 92% compliance in March 2019 and 100% in June 2019 and September 2019.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Incidents and near misses were recorded on an electronic reporting system.

In the reporting period of July 2018 to June 2019, there were no never events or serious incidents. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic barriers are available as at a national level and should have been implemented by all healthcare providers.

There was a hospital total of 40 clinical incidents reported, of which 38 were classified as either low harm or no harm. Of these incidents 18 were for surgery.

There had been two incidents reported as moderate harm; one for a patient.

The service used a root cause analysis approach for investigations of incidents and the manager had received training to complete. Themes and trends were reviewed with any learning shared through clinical governance, medical advisory (MAC) and health and safety committees.

Team meeting minutes we reviewed including the sharing of incidents across the organisation.

There was a policy for critical incident reporting and management with a review date of 2020 and there was serious untoward incident policy, however; this was past the review date of April 2019.

There was a duty of candour policy. (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons)

Surgery

of 'certain notifiable safety incidents' and provide reasonable support to that person). Staff we spoke with understood that duty of candour was about being open and transparent with patients and those close to them.

Are surgery services effective?

Outstanding



We rated it as **outstanding**.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The service followed the Royal College of Ophthalmologists (RCOphth) standards. Policies and procedures were in place for all staff access on the company Intranet. As part of the recent Clinical Governance Strategy there was a planned review of the policies, procedures and the processes in progress.

The service carried out quarterly clinical audits that covered key topics. Any audits that were less than 90% compliant, had actions identified, and the audit was repeated one month later.

A programme of clinical audit was in place covering key areas such as WHO Checklist compliance, hand hygiene, medicine fridge temperatures and medical record keeping quality. Substandard (<90%) audits were investigated, learning applied and re-audited to ensure learning loops were effective. A new electronic tool for auditing was being introduced to improve visibility of audit results and learning and allow for better benchmarking.

The services referral to treatment target was six to seven weeks. A weekly activity meeting was held that monitored this and additional theatre sessions were created to meet the demand.

Waiting times from time of arrival to departure through each stage of the patient journey were monitored as part of key performance indicators to monitor and action if there are areas that need addressing.

Nutrition and hydration

Complimentary refreshments of tea, coffee, biscuits and cold water were available to all patients and their relatives when they attended for their appointments.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Pain audits were completed immediately after discharge, by reception staff in face to face discussion and through a questionnaire which fed into the patient reported outcome measures (PROMS).

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The provider submitted to the Royal College of Ophthalmologists national clinical audit programme known as the National Ophthalmology Database Audit (NODA). The provider submits 100% of its data. Results were better when compared to similar services nationally except for 6/12 vision. From the 2018 programme:

- the adjusted posterior capsular rupture rate was 0.5% (National 1.1)
- the visual acuity loss rate was 0.1% (National < 0.9%)
- 6/12 or better 95.46% (national target >95%)
- refractive outcome within 1D 88.75% (RCOphth >85%)

The provider submitted data to the European Registry of Quality Outcomes for Cataract and Refractive Surgery (EUREQUO). This was a database for providers to benchmark across Europe.

Surgical quality was monitored using the service's RAG rating system where complication rates, visual outcomes and PROM data related to the surgery experience were reported in live time and reviewed at board meetings bi-monthly. Surgeons were monitored by this process system for complications, infection rates and bedside manner. If there was an area highlighted, the MAC reported back to them direct to help enhance their outcomes.

Surgery

Audits of biometry testing were carried out in June 2019 and September 2019 with a compliance of 100%.

Outcomes were benchmarked across the organisation that identified good practice and areas for support and focus.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Staff did not practice in any role until assessed as competent. Every new staff member shadowed patient's through their treatment journey as part of their induction to ensure they are more understanding of what patients experience.

Team members were only be considered 'in numbers' once they were deemed competent to ensure clinical quality and patient care is of the highest standard. The service ensured that the practising team had appropriate skills with additional resources sourced due to the potential complexities of the service or skill-mix of team members. The headcount was increased to ensure that they had the appropriate level of clinical experience and that the clinical staff were suitably supported.

Each staff member was required to undertake training to understand the organisations standards in their approach to surgery and optometry, and then work to standards expected.

As the organisation's headquarters, there were shadowing programmes for new clinical staff with a two day induction. All staff, clinical and non-clinical followed a patient through their journey to help with understanding of the process so they could explain it to patients.

The service maintained a skills matrix that indicated staff who had been trained and deemed competent for certain roles and responsibilities.

In the reporting period of May 2018 to April 2019, all staff had received an appraisal.

Skills of registered nurses had increased to include surgical scrub and age related macular degeneration injectors.

All staff were required to attend a core of knowledge course with an external provider. This was routinely refreshed every three years, although would be less if any concern was highlighted. An external laser protection advisor (LPA) had been identified who had developed the local rules for

the location. The nominated laser protection supervisor (LPS) had completed level four training in laser treatment that included face to face and e learning elements. There was no nominated deputy for the LPS although staff, with appropriate skills and training could be re-deployed from other locations across the region.

Newly appointed surgeons had a period of supervised practice under a lead surgeon. The service monitored quarterly comparative complications, infection rates and patient bedside manner for surgeons using a RAG rating tool. Any concerns were managed directly.

Surgeons and optometrists performance was monitored and reviewed at governance and medical advisory committee meetings that focussed on outcomes as well as patient experiences.

Staff were supported to develop their roles and this was reflected in the staff survey in May 2018.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was effective working between all staff, that we observed, at the location with good teamwork.

Multi-disciplinary daily morning huddles and debriefs were held in the hospital led by the clinical lead on the day, normally the registered manager to plan and review the day's activities collectively.

The service worked well with external stakeholders including commissioners and G.P.'s as well as private optometry services.

Seven-day services

Key services were available seven days a week to support timely patient care.

Operating times are between the hours of 07:30 until the end of the surgical list which on average is complete by 6pm.

Depending on the demands for the service, additional surgical lists could be planned for weekends. The rotas reviewed included planned weekend activities for both Saturday and Sunday.

Surgery

The emergency helpline was available 24 hours a day, seven days a week and the dedicated call centre was staffed from 8am to 6pm Monday to Saturday. Patients were informed verbally and in writing in their discharge information.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Patients were given discharge advice both verbally and written leaflets.

Information including advice about keeping the eye clean as well as driving or operating machinery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

We observed staff obtaining verbal consent from patients before providing care.

Written consent was obtained before surgery and recorded in the patients paper records. Optometrists had completed Mental Capacity Act (MCA) and consent training. We observed an optometrist who was very thorough in gaining informed consent from a patient providing options available to them.

There were provider policies for Mental Capacity, for staff to follow that included involvement of an independent mental capacity advocate (IMCA) if needed.

MCA and consent training was mandatory for all staff to ensure patients decisions were appropriately supported particularly when making decisions about surgery. There was 95% compliance with MCA training for clinical staff and 10% for non-clinical staff.

There was an interpreter service available to help with consent for patients whose first language was not English.

If patients lacked capacity to make their own decisions staff made decisions about care in the best interests of patients and involved their representatives and other healthcare professionals appropriately. This may include referring back to the NHS for care and treatment.

Are surgery services caring?

Good 

We rated it as **good**.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed staff interacting positively with patients and those close to them. These included medical staff, allied health professionals and support staff as well as nurses. Staff spoke to patients sensitively and appropriately depending on individual need.

Staff introduced themselves and communicated well to ensure patients fully understood. Patients were encouraged to ask questions and were given time to ensure they understood what was being said to them.

The service requested patient feedback immediately post-surgery, on leaving the hospital and during community optometrist checks, as well as carried focus groups to obtain more feedback from patients.

Feedback was shared through weekly email updates and monthly newsletters with staff.

Compliments were recorded on the organisations electronic reporting system.

The service submitted feedback data to the NHS Friends and Family Test (FFT). Between February 2019 to July 2019, the FFT was an average of 99.5% recommend per month with an average response rate average 90%.

We observed three patients, during clinic preassessment consultations and three patients on the day of surgery, with different staff members. All introduced themselves and explained all care and treatment either to patients alone or accompanied by a relative.

Surgery

We spoke with eight patients and six relatives. All those we spoke with were very positive about their experience and care received. They had all been given a choice of where to go for care. They were told that they would have longer waiting times for their local NHS hospitals whereas they would only need to wait up to six weeks if chose SpaMedica. They were also offered the chance to join a cancellation list, which applied to two patients we spoke with. Patients spoke highly of all the staff, through their treatments with some returning patients for their other eye or for planned regular treatments of age-related macular degeneration (AMD).

All clinic consultations were held in private rooms although there was no signage, except for the YAG laser room, when to indicate if a patient was in the room. This meant staff needed to knock on doors and entered to leave notes. We were told that all signage was being reviewed.

Patient satisfaction was recorded at several points in the patient pathway and logged using a database reporting tool. There were key questions (pain and surgeon manner related) that the discharge nurse asked after the operation. If there was any negative feedback an alert was sent directly to the manager who discussed actions. Pain audits were completed immediately after discharge, by reception staff in face to face discussion and through a questionnaire which fed into patient reported outcome measures. The questionnaire included questions on the surgeon's manner and the patient's general satisfaction with the way they have been treated by all staff.

Feedback was shared through staff weekly updates and monthly newsletters.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff members were available to support patients during treatments.

We observed staff providing reassurance and comfort to patients both in private consultations and also during the surgical procedure. Staff were calm and supportive providing extra time to these patients.

Patients were provided with the organisations "patient stories" DVD where previous patients described their experience to help relieve anxiety. Videos were included in the organisations website.

If a patient was assessed to be very anxious, they could be prescribed a medicine to help with the nervousness.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff respected patient choices and delivered their care with an individualised person centred approach.

There was a chaperone policy in place, however; we did not see any posters for patients to highlight this. Patients could be accompanied by someone close to them in clinics and theatres; "hand holders" were made available for extra support if needed.

Patients and those close to them told us that they received information in a manner that they understood before and after the procedure.

Are surgery services responsive?

Good 

We rated it as **good**.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Between July 2018 to June 2019, there were 6 239 day case episodes of care recorded at the hospital; all of which were NHS-funded. There were 3 702 visits in the operating theatre.

There were 6 863 outpatient total attendances in the reporting period.

The service treated adult patients only, over the age of 18 years and only elective patients according to the parameters set by their local commissioners.

Surgery

Patients were from the local area, although some had travelled across the county as they were told waiting times were shorter than if they attended their local NHS hospital.

The service was routinely open five days per week, although extra lists were added regularly at weekends to meet the demands of the service.

Complimentary tea, coffee, biscuits and water were available with nominal charges for other hot drinks dispensed.

The provider website included patient stories that could be viewed at home. Alternatively free DVD's were available for patients to take home and watch prior to their planned surgery. Senior staff told us that a videographer had been employed to increase the videos available, such as in Urdu for patients whose first language was not English.

The hospital operating times were between the hours of 7.30am to the end of the surgical list, which on average was completed by 6pm.

The organisations helpline was available 24 hours a day and seven days a week for patients following discharge. Optometrists and surgeons were available to talk to patients with the dedicated call centre being staffed from 8am-6pm Monday to Saturday. Patients were made aware of this verbally and in writing in their discharge information.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service was on the ground floor of a tower block with multiple fire exits in case of emergency.

The service could accommodate patients, weighing up to 160kg, on the theatre operating table, although any patient needed to be able to transfer onto the table independently.

There was complimentary parking with an intercom entry. Entry from the car park included a set of stairs, therefore; staff on reception checked if there were any mobility needs and directed patients to an alternative entrance where a wheelchair was provided.

Wheelchairs were available for patient use if required. There was a range of chairs; some with arms and others without.

Disabled toilet facilities were available as well as other unisex toilets.

The service had dementia champions and staff had completed training.

Free patient and carer transport was offered, for patients attending for cataract surgery, within a 10 to 30 mile range of the hospital with patients safety to travel risk assessed individually. Drivers collected patients from their home with a reminder the day before of the expected time. We found that this was not offered to patients attending for age-related macular degeneration. Senior managers told us that this was because patients had to attend on certain days to ensure the best outcome for treatment and was not always practical to plan.

If patients were delayed at the hospital, taxis, free of charge were provided for their journey home.

For patients whose first language was not English, an interpreter service was available either face to face or by telephone. These were pre-booked when needed.

Written information was available in languages other than English, although the organisations website did not include a translation facility.

Leaflets could be accessed in formats such as larger print, however; there was no pictorial leaflets for patients with a learning disability or limited reading skills.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Referrals were received by phone and patient contacted within 48 hours to book an appointment, from the providers headquarters.

Patients were offered a choice of appointment, including weekends. The services referral to treatment target was six to seven weeks. In the 12 months prior to inspection, patients waited an average of 21 days from referral to pre-assessment clinic and an average of 25 days from clinic

Surgery

to cataract surgery. For YAG laser, the average wait was 30 days from referral to pre-assessment clinic and an average of 19 days from clinic to laser treatment. There was an average wait time of 10 days from referral to acute macular degeneration (AMD) clinic with treatment injections at the same time.

In the twelve months prior to inspection, there were 45 patients cancelled due to non-clinical reasons. Some were due to environmental factors including water leaks, cataract phaco machine not operational and electrical faults. The service was undergoing a programme of refurbishment. Other reasons including lack of an available surgeon or interpreter. The main other reason was patient choice. There were 10 patients who waited longer than 28 days to be re-booked; these were due mainly to either patient preference or needed a second referral for other eye.

Between January 2019 and October 2019, there were 11 patients cancelled for clinical reasons. These were mainly due to patients requiring a general anaesthetic or unable to tolerate the theatre bed or had other health concerns.

Between July 2018 to June 2019, there were no unplanned returns to theatre and no unplanned readmissions.

The service monitored the utilisation of services. Between October 2018 and September 2019, the average utilisation for cataract pre assessment clinic and YAG laser clinic was on average 87%. For cataract surgery and YAG treatment, utilisation was on average 95%.

For age related macular degeneration (AMD), for 2019 to date, the provider saw 8% of patients within 24 hours, 20% within 48 hours, 24% within 72 hours and 74% within seven days. All patients were seen within 14 days in line with the National Institute for Health and Care Excellence guidance.

Waiting times were monitored from time of arrival and departure times from each stage of the patient journey. Between July 2018 to June 2019, the time to be seen in pre-assessment clinic was an average of 27 minutes for cataracts and 20 minutes for YAF laser. The post-operative clinic wait time was on average 34 minutes. The treatment wait time was an average of 27 minutes for cataracts and eight minutes for YAG laser.

The numbers of patients who did not attend were recorded. Between October 2018 and September 2019, there was a total of 64 patients who did attend for cataract surgery and seven patients who did not attend for YAG laser treatment.

Learning from complaints and concerns

There was a complaints policy in place which was accessible to staff electronically.

In the reporting period of July 2018 to June 2019 the service received six complaints, none of which were upheld.

Patient complaints leaflets were available at reception areas advising the patient of the ways in which they could provide feedback or log a complaint. Leaflets offered the choice of escalating their complaint to another senior manager, and the website sign posted patients to the Parliamentary Health Services Ombudsman (PHSO).

Once a complaint has been received this was added to the electronic incident reporting system and allocated to the hospital manager so the investigation and action plan could be logged.

There were timescales of three working days for the initial acknowledgment of the complaint and then 20 working days for the hospital manager to complete an investigation and provide a detailed response. If more time was required an update was issued to the patient to make them aware of the revised timeframe.

Complaints were regularly monitored by senior managers. The process and emerging themes were discussed where appropriate at the clinical governance committee meetings.

Any learning was shared at daily huddles, via email, newsletters and team meetings.

Example of changes made from patient feedback were in relation to comfort including, bariatric wheelchairs purchased for the hospital. Following feedback waiting room chairs not with arm rests were purchased.

Surgery

Are surgery services well-led?

Good



We rated it as **good**.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service had recently appointed a new hospital manager who was an experienced current employee. There was a planned period of training, induction and mentorship.

In response to recent changes of staff members the service had increased visibility from the senior team including the area manager

The senior management team encouraged openness with an operational structure to support this whilst encouraging engagement across all disciplines.

Managers were visible and frequently visit hospital sites encouraging staff engagement, attending monthly meetings.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The visions and values were included as part of the organisations website.

A clinical governance strategy for 2019/20 was in place to enhance effective governance and culture using clinical quality key performance indicators.

Strategic objectives were to deliver a world class service to patients, operate safely and effectively, operate effectively and in compliance with legislation, be the employer of choice within ophthalmology and support transformation to deliver care closer to home.

The service promoted transparency, integrity, safety and kindness.

The leadership of the organisation shared a vision for high quality and patient safety and have invested building an experienced, patient focused board and senior management team with the provider being patients first choice for their cataract surgery.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was a positive attitude and culture where staff valued each other. Staff reported good team working and a sense of pride providing continuity of care using a team approach.

All staff, we spoke with, were passionate about the service they provided.

Staff we spoke with had been employed for varying lengths of time with recently appointed staff reporting feeling supported by their managers to discuss ways of improving services to provide quality care for patients.

Staff told us they felt valued and appreciated by the senior managers.

The organisations values were: "Treat every patient as though they are your parents" for every patient, every time: no exceptions and no excuses.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Surgery

There was a process and policy in place to monitor and review practising privileges for medical practitioners to ensure standards were adhered and concerns escalated. This had been reviewed by the medical advisory committee (MAC). Surgeons were interviewed and their outcomes for patients reviewed prior to forwarding recruitment documentation. New applications were received with a process where individual applicants were reviewed and accepted to supervised practice assessment, before having practising rights approved. The lead surgeon observed the applicants during a trial operation list followed by supervision with a limited number of patients initially increasing to a maximum of 24.

The MAC had quarterly meetings where any incidents, updates in policy and performance were discussed. The service's responsible Officer (RO) at MAC meetings supported onboarding practicing privileges procedures and ensured those surgeons that were connected to a designated body other than SpaMedica received the same scrutiny through contact with their own ROs. Surgeons were monitored by a RAG rating system for complications, infection rates and bedside manner. If there was an area highlighted, the MAC reported back to them direct to help enhance their outcomes.

The human resources team monitored individual consultant files, checking registration with the General Medical Council (GMC), professional indemnity, appraisals and responsible officer reports. The MAC reviewed the monitoring processes with a responsible officer on the MAC.

Significant incidents and themes were reported and discussed at the organisations national clinical governance and clinical effectiveness bi-monthly meetings, medical advisory and health and safety committees.

Complaints were monitored by the executive assistants, chief operating officer and director of clinical services. The process and emerging themes are discussed where appropriate at the clinical governance committee.

The clinical audits were discussed at clinical governance meetings. Changes to policy or practice were implemented by the clinical effectiveness group.

Audit outcomes were discussed at monthly board meetings.

As part of the organisations clinical governance strategy there was a planned review of the policies, procedures and processes.

Monthly operations team meetings and clinical governance meetings included representatives from all the organisations locations. Regular agenda items were discussed, such as incidents, patient satisfaction and safeguarding, with actions identified.

There was a service level agreement in place with the laser protection advisor (LPA). Local rules were in place that all staff who operated the YAG laser were required to read and sign. We observed that the laser protection supervisor (LPS) had signed the rules but they were not signed by the 'runners' who supported the LPS as identified in the rules.

The provider had introduced a risk assessment to ensure that when there was variance from the standard recruitment checks, for staff, they could assess the risk to ensure patient safety. The recruitment policy had been amended to reflect the changes that included reference and health checks.

We reviewed a sample of five staff recruitment files. Of these we found that four of the five included a risk assessment to indicate any absent documents. Three of the five did not include record of an interview, and only one included any appraisal information. For staff with professional registration, there was no evidence of a check when first employed. We were told that registration was checked when renewed. Disclosure and barring checks were carried out following offer of employment. Senior managers told us that staff were supervised until the results of the check had been received.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was a company-wide risk register in place in addition to a specific hospital risk register which was reviewed and maintained by the hospital manager.

Surgery

The hospital risk register was maintained electronically and therefore did not include dates when presented as a spreadsheet.

Risks were divided into patient, staff, quality, statutory and environmental risks that were mainly potential risks identified. The risks indicated that they had been reviewed recently, with control measures in place.

The corporate, company-wide risk register were discussed at operational meetings.

Senior managers were committed to providing quality care for patients. Surgical performance was monitored quarterly, on a dashboard that included outcomes of surgery and bedside manner using a rag rated system. Examples were provided where surgeons had been identified as requiring additional support when to improve scores.

The service had introduced a structure that encouraged participation from staff at all levels with meeting decisions cascaded to all staff and managers open to staff suggestions.

There was a business continuity plan in place to safeguard records should there be any electronic or power outages.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Patient details were maintained initially using a combination of paper and electronic systems. Following discharge, paper records were scanned onto the electronic systems. These were backed up in case of accidental failure.

Staff could access information via the organisations intranet and via emails. Staff we spoke with said that senior managers were very responsive to any queries.

The service submitted 100% of their data to benchmark and monitor their clinical outcomes nationally.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff feedback was encouraged through six monthly staff surveys and forums. Hospital roadshows were held where the board listened to staff concerns, sharing planned changes in response including improvements to the staff travel policy.

The organisation liaised with local charities to support continued care in the community.

Staff receive updates via the organisations intranet, weekly emails, monthly newsletters and monthly team meetings.

Multi-disciplinary daily morning huddles and debriefs were held in the hospital led by the clinical lead on the day, normally the registered manager to plan and review the day's activities collectively.

The organisation had achieved gold for Investors in People valid until 2021.

Staff attended annual summer and Christmas social events where they had opportunities to engage with the whole company who shared the same values.

Staff had set up forums as well as social media groups to support each other.

The service held education evenings and events for community optometrists to improve care and cross provider engagement to support ongoing patient care in the community. They introduced their optometrist accreditation scheme for post-cataract surgery patients meaning patients post-op could be done in the community optometrist setting. This involved the provider training and accrediting community optometrists to safely see post-op patients.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Surgery

The medical director carried out research into social deprivation and the impact it has on cataracts. This has been presented at ophthalmic conferences and was published in a national magazine for the medical profession.

The service has been nominated for a national antibiotic guardianship award for supporting the appropriate use of antibiotics for cataract surgery.

Outstanding practice and areas for improvement

Outstanding practice

The service achieved good outcomes, that were continuously monitored, with patients reporting a positive experience.

The service had an endophthalmitis box on site in case of an emergency.

Patients stories were available as DVD's or on the website

The service provided free transport to patients who lived within a set distance from the location.

The service offered an accreditation scheme for community optometrists

The medical director carried out research into social deprivation and the impact it has on cataracts.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that local rules and any recommendations from the authorised laser protection advisor are followed safely.
- The provider should ensure that all doors to clinical areas, such as the theatre, are secure.
- The provider should ensure that the safeguarding policy for children references current guidance.
- The provider should ensure all policies are reviewed and reflect current guidance within agreed timelines.
- The provider should consider alternative formats for leaflets and website information.
- The provider should consider how to indicate a room is occupied to help prevent interrupting appointments.
- The provider should consider posters to indicate a chaperone is available.
- The provider should consider reviewing service level agreements in line with best practice.