Moorfields Eye Hospital NHS Foundation Trust

Moorfields Eye Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Good
Surgery	Good
Services for children and young people	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Moorfields Eye Hospital City Road is part of Moorfields Eye Hospital NHS Foundation Trust. The trust has 32 centres in and outside of London. It provides a networked satellite model of care at Moorfields Eye Hospital City Road and across three geographical networks: Moorfields North, Moorfields South and Moorfields East. Services provided include surgery, outpatients and professional support to other eye services managed by other organisations.

Moorfields Eye Hospital City Road is located in central London. The hospital provides comprehensive general and specialist outpatient, diagnostic and surgical services for the local population and for those from further afield who require more specialist treatments not available elsewhere. Islington Clinical Commissioning Group is the lead NHS commissioner of services provided by the trust, with over 28 key associates to the contract. As well as providing clinical services it is the trust headquarters.

Our key findings were as follows:

- There was an open and transparent approach to incident reporting. Staff were encouraged to report incidents but feedback and learning from incidents was variable..
- Medicines were managed safely with relevant checks carried out.
- Care and treatment was delivered in line with best practice and staff had ready access to and followed protocols and guidelines driven by national guidelines and best practice. Medical staff contributed to the development of national standard setting and guidance.
- Patients had access to new and innovative treatments through participation in research studies. At the time of our inspection there were a significant number of studies underway, including: six adnexal, nine age related macular degeneration, three cataract, nine corneal external disease, three diabetic retinopathy, eight glaucoma
- There was good multidisciplinary team working involving staff from a range of specialities including and orthoptists and optometrists.
- Staff were aware of the signs of potential and actual abuse and knew the action to take to protect children and adults.
- Patient risk was assessed but, the full five steps to safer surgery had not been fully Implemented and embedded in operating theatre practice.
- Patient outcomes were monitored and benchmarked nationally and internationally. The hospital provided information to the World Association of Eye Hospitals' (WAEH), which compiled an annual report demonstrating the numbers of attendances and interventions in comparison with other eye hospitals globally.
- Patients had their pain regularly assessed and managed effectively. Child friendly pain assessment tools were used.
- For patients who were having surgery a range of sandwiches and drinks were available following their procedure. Following surgery children were offered drinks, a choice of sandwiches, cereals and ice cream.
- Staff had access to on-going training and development and the uptake of appraisals was good.
- We found caring was good in all the services we inspected and in services for children and young people it was outstanding.
- Patients described staff as caring, kind and compassionate. Staff tried to reassure patients and put them at ease prior to their surgery. In services for children and young people all staff engaged with children and their parents to reduce their anxiety and reassure them;" they turned a scary place into a friendly place."

Summary of findings

- Patients and their families told us staff spent time explaining their assessments and treatment options. They didn't feel "rushed" and had time to ask questions..
- Psychological and emotional support was provided by staff and the integrated patient support team also gave practical advice and information on services outside the hospital.
- The process for managing and responding to complaints was well developed. Where possible staff tried to resolve patient concerns immediately. We saw evidence that the findings from investigations were shared with the patient along with an apology.
- Most services had good governance and risk management processes to monitor and evaluate care.
- Staff told us they were proud to work for the trust and most felt valued. They were aware of the trust's values.
- The hospital provided updates to staff using a range of methods including weekly newsletters and 'In your shoes' session where staff were given feedback about patient experience and contributed to discussion about improving the patient experience.
- Staff in the A&E and pharmacy department staff raised concerns about bullying and harassment and the hospital had taken a range of actions to address the problems in these areas.
- The environment in the accident and emergency department (A&E) did not meet the needs of children and young people or protect patient's privacy. There were also problems with the ventilation in the A&E and limited storage space for patient records.
- Areas we inspected were clean but, space in the outpatients department was limited and there was insufficient seating for the number of patients attending clinics.
- The availability of medical records was an on-going issue and temporary notes were used until the records could be located.
- We found omissions in some patient records including staff signatures and record entry dates.
- There was a general laser risk assessment however, these were not dated. Laser safety guidelines on the intranet were dated October 1999 and although more up to date guidelines were available staff were not aware of them..
- The hospital had taken some action to cope with the increasing demand on services; extra consultants had been employed to work in the A&E and audits had been carried out to identify urgent and non urgent attendances and make GPs aware of the services provided by the A&E to reduce inappropriate referrals. Extra clinics were being held in the evenings and on Saturdays to cope with the busy caseloads in the OPD.
- There were delays with patient flow in some services. In surgery there was significant variation in the number of children undergoing surgery on different days of the week. Outpatient clinics often over ran and patient waiting times were not monitored.
- Many staff spoke positively about the leadership of their service, although some staff in the outpatients department lacked confidence in the management because of the lack of action to address some of the on-going problems.

We saw several areas of outstanding practice including:

- Staff's sensitivity to the needs of children, young people and their families was outstanding.
- Play staff were able to engage with children on a one to one basis to provide age appropriate activities and distraction when they became anxious. This input was available in all areas of the RDCEC including A&E and outpatients clinics.

Summary of findings

- The written information provided for children and young people was of very high quality. An internet resource had been designed for children and young people, giving information about eye conditions. It was divided into three different age groups and also had an animated eye, a virtual children's eye hospital and other interactive features suitable for children.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure the World Health Organisation (WHO) surgical safety checklist is consistently implemented for all surgical procedures including the five steps of team brief, sign in, time out, sign out, and debriefing.
- Ensure adequate audit and monitoring systems are in place to monitor performance and compliance of the five steps to safer surgery safer surgery checklist to guide improvement.
- Ensure that the quality and safety of the outpatients service are fully monitored, including patient waiting times and clinic finish times.
- Ensure that risks relating to patient waiting times are fully mitigated.
- Ensure that patient records are fully and legibly completed, including staff signatures, record entry dates and documentation errors correctly marked.

In addition the trust should:

- Look for ways to improve patient privacy in the OPD, accident and emergency department and day case wards.
- Address the lack of storage space for patients' notes in ED and the administrative office and remove barriers to evacuation.
- Consider implementing the business plan for an electronic record system and scanning of casualty cards. This will free up space within the administration office and eliminate the risk of trips.
- Repair the ventilation system within the emergency department.
- Improve the waiting area for children and young people in the main accident and emergency department.
- Ensure all staff complete all aspects of mandatory training.
- Ensure all staff are aware of the incident reporting process.
- Ensure all staff have knowledge and awareness of the duty of candour principles.
- Review and update, as appropriate, risk assessments and guidelines for lasers and ensure staff are competent to use them.
- Ensure staff have the correct training and implement formalised systems to monitor and record staff training information for paediatrics within the theatre department.
- Improve the availability and storage of medical records.
- Work to reduce the number of operations cancelled due to theatre cancellations.
- Develop a strategy for services for children and young people and consider how reporting about plans, priorities and the quality and safety of the service could be improved.
- Improve the uptake of appraisals and ensure all staff are aware of their responsibilities in relation to the Mental Capacity Act 2005.
- Consider how documentary information and signage could be improved for people with visual impairment
- Ensure all staff are aware of the electronic flagging system for vulnerable patients, such as those living with dementia or a learning disability in the outpatients department.
- Ensure that the environment of the outpatient department is routinely monitored and appropriate actions are taken to ensure patient safety, comfort and welfare.
- Ensure emergency buzzers are available in radiology.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	We rated the accident and emergency department as good overall because: • There were effective systems to minimise risk to patients including reporting and learning from incidents and infection prevention and control policies and practice. • Adults and children were protected from the risk of abuse because staff were aware of the policies and procedures and the action to take if they suspected potential or actual abuse. • Patients were cared for by competent staff who had the relevant skills and experience and had completed their mandatory training. • Care and treatment was evidence based and the hospital participated in national and local audits to monitor patient outcomes. Clinicians were involved in the development of national standards and guidelines. • Performance against the four hour waiting time national standard was above 95% and unplanned re-attendances were below the national average. • There was good multidisciplinary working and the hospital worked closely with other local trusts who could provide care for patients with other general health problems. • We observed staff being courteous towards patients and providing compassionate care. Patients told us they felt safe in the unit and involved in decisions about their care and treatment. • The number of patients attending the department was increasing year on year and the hospital had taken some action to cope with the increased demand on the service. • The service was able to care for patients with specific needs such as those with a learning disability or dementia. For patients whom English was not their first language information was available in different languages along with an interpreter service.

Summary of findings

- Most staff were positive about their managers and said they were visible and supportive and appreciated their hard work.
- Systems to monitor risk and the quality of care were effective.
- Some staff felt they were not treated equitably and had raised their concerns with senior staff who had taken action including providing staff were with specialist training on different types of discrimination and how people from different cultures could perceive each other.

However:

- The waiting area for children was not suitable and did not meet their needs; space was limited and some children and their families used the adult waiting area
- There was a poor ventilation system in the A&E which meant at times the waiting area was very hot and there was a lack of storage space for patient's notes.
- Some nursing staff were unsure about their responsibilities in relation to the Mental Capacity Act 2005.
- Patient privacy was not always maintained due to insufficient space between treatment cubicles.
- Patient engagement was limited to surveys and patient feedback forms.

Surgery

Good

We rated surgery as good overall because:

- There were sufficient numbers of staff to care for patients
- Staff adhered to infection prevention and control policies and the areas we visited were clean and free from clutter, although storage space was limited.
- Resuscitation equipment for adults and children had been checked and medicines and controlled drugs were stored securely.
- Care was delivered in line with best practice guidance and there were good patient outcomes, with some better than the national standard, across the specialties.
- All staff had access to training and development opportunities and the hospital had plans for managing revalidation for nursing staff.

Summary of findings

- Patients were involved in discussions about their care and treatment and told us staff had explained their procedure to them.
- We observed staff providing compassionate care, listening to patients and providing reassurance. Patients described staff as “kind” and said they “put them at ease”.
- Work was being undertaken to improve patient flow through surgery. This included patients being able to have their pre-assessment following their outpatient appointment and a ‘one-stop’ nurse led assessment clinic which including investigations if needed and a live patient tracking system.
- Theatre utilisation was at 90% met the trust target and was better when compared with other locations.
- Staff had received training in how to care for a patient with a learning disability and a specific welcome pack had been developed for this group of patients. They had also received training in caring for patients living with dementia and each area had link nurses for these patients.
- Information about how to make a complaint was visible in patient areas and we were given examples of learning from complaints. The majority of complaints were about waiting times on the day of surgery.
- There was a vision and strategy for the service and senior staff were aware of them and their role in delivering them. Although less experienced staff were not so aware of them they could describe their role in delivering and improving patient care.
- Risks were recorded and escalated to the trust register in line with policy. Information about the quality and safety of care provided was shared with staff through monthly and weekly staff meetings.
- Staff told us they leadership was visible and had “an open door policy”. They were proud to work for the trust and felt supported and described the culture as “inclusive”.

However:

Summary of findings

- The World Health Organization (WHO) Surgical Safety Checklist was not fully embedded in theatre and audit information and observations demonstrated that improvement was required.
- There was no formalised competency assessment process to ensure staff had the adequate skills and knowledge to care for paediatric patients in the recovery area of theatres.
- Mandatory training levels in some areas were below trust targets including resuscitation training which 108 staff within the surgical services needed to complete.

Services for children and young people

Good

We rated services for children and young people as good overall because:

- There were systems for reporting and learning from incidents and staff were aware of them and their responsibilities under duty of candour.
- Areas we inspected were clean and child friendly with secure entry.
- The service had its own pharmacy open Monday-Friday 9-5.30pm and staff had access to a pharmacist outside of these hours. Medicines and controlled drugs were stored securely and checked in line with hospital policy.
- Children were admitted as day cases but if they needed to stay overnight the hospital had agreements to transfer them to other local trusts which provided children's services.
- Staff were aware of the child protection policy and procedures and had access to a named nurse. They could describe the action they should take if they suspected potential or actual abuse.
- Nursing staff levels were in line with the Royal College of Nursing standards for staffing levels in children and young people's services (2013) and the majority of staff were trained to care for children. In recovery there was only children's trained nurse but, the other staff were experienced in caring for children.
- Policies and guidance had been developed in line with current best practice guidance including guidance from the Royal College of Ophthalmologists (RCOphth) and the Royal

Summary of findings

College of Paediatrics and Child Health (RCPCH) and consultants had contributed to the development of national best practice guidelines published by the Royal Colleges.

- Staff were sensitive to the needs of children and young people and were quick to recognise, and respond, when they needed some additional support or quiet time.
- Parents were involved in their child's care and treatment and we observed staff speaking with children and young people in a way that enabled them to gain a full understanding of their treatment plan and take an active role in decision making.
- Children, young people were overwhelmingly positive about the kindness and compassion of staff.
- The service had increased the number of consultants to meet the increasing demand on the emergency department and some action had been taken to improve the flow of patients through the outpatient's services to reduce repeated attendances and waiting times as much as possible.
- Children and young people could usually be accommodated with others of the same gender or a similar age according to their needs and preferences. The service was sensitive to the needs of children and young people with a learning disability or autism and arranged their care to minimise waiting times.
- There were a range of activities and toys to available to keep children and young people occupied and they also had access to the family support service.
- The service had systems for monitoring the quality and safety of the care provided and information was shared with staff at quarterly half day governance meetings.
- Staff felt they were treated equally and were encouraged in their development and to put forward their views.
- There was a strong culture of putting children and young people first and they had been involved in the development of the service and improving patient experience.

Summary of findings

However:

- There was no information to demonstrate the consistent use of the WHO safer surgery checklist in children's and young people's services and a general surgical audit indicated poor compliance.
- There was no clear strategy for the future development of the service.
- There were no clear quality targets or priorities for the service.

Outpatients and diagnostic imaging

Requires improvement

We rated outpatients and diagnostic imaging as requires improvement overall because:

- There were systems to monitor the safety of care provided and mitigate risks but some of them needed further development.
- Some patient records we reviewed were incomplete with no signature or name and unfinished entries. Referrals were paper based and there was no system to monitor or audit referrals once received.
- There were a number of problems with the environment including some areas becoming too warm, problems with the automatic doors at the entrance to some clinics and insufficient seats for the number of patients attending clinics. There were no emergency buzzers in the radiology department.
- Clinics were frequently overbooked, finished late and there were long waiting times for patients once they arrived for their appointment. They were not kept informed about waiting times.
- Patients were seen in open cubicles which sometimes made it difficult for staff and patients to hear what was being said.
- Written information for patients was in small font and patients told us the signage was not always clear.
- Some of the key issues identified during the inspection such as patient flow and waiting times in the outpatient clinics and clinics overrunning, were not formally monitored by the leadership team and we did not see evidence that they were being addressed.

Summary of findings

- The solution for the problems with the current environment was a newly built hospital but, it was unclear what short/medium term plans were in place to mitigate the issues while waiting for the new hospital.
- Confidence in the leadership was variable among staff because of the lack of action in response to problems identified and escalated to them.

However:

- We observed good infection prevention and control practices and the environment in both OPD and diagnostics and imaging were clean.
- Most staff groups were close to achieving the trust's target of 80% for completion of basic life support training.
- Care and treatment was evidence based and care was audited.
- All staff had a good awareness of child protection and safeguarding adults procedures and the action to take if they suspected actual or potential abuse.
- Diagnostic imaging had a Local Rules' policy, reviewed in November 2015, to ensure compliance with health and safety legislation relating to exposure to radiation.
- A Radiation Protection Officer was available within the department during working hours
- Equipment was regularly serviced with maintenance checks carried out as needed.
- We observed many positive caring interactions between staff and patients were complementary about the care they received.
- The OPD was meeting the 18 week referral to treatment target with 50% of patients waiting no longer than 11 weeks from referral for their first OPD appointing.
- Patients could access diagnostics and imaging on a walk in basis and were almost always seen on the same day, with short waiting times.
- Staff told us they felt valued and appreciated the support they received from their managers.

Moorfields Eye Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Surgery; Services for children and young people;Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to Moorfields Eye Hospital

Moorfields Eye Hospital City Road in central London provides comprehensive general and specialist outpatient, diagnostic and surgical services for the local population and for those from further afield who require more specialist treatments not available elsewhere. It also provides emergency surgery, a 24-hour A&E dealing exclusively with urgent eye problems, and pre-eminent research and education capability. Services are delivered from the main hospital, children's centre and private facilities. The City Road campus is also home to the trust's research partners at the UCL Institute of Ophthalmology.

The hospital has 18 inpatient beds and 41 day case beds, (12 are reclining chairs) including 12 for children and young people. The hospital employs staff.

Our inspection team

Chair: Dr Peter Turkington

Head of Hospital Inspection: Nicola Wise

The hospital was visited by a team of twenty four people including CQC inspectors and a range of specialists. The team included CQC inspectors and a variety of specialists. There was a consultant ophthalmologist and the team also included nurses with backgrounds in ophthalmology, surgery, paediatrics and emergency care and board level directors. We had one expert by experience assisting us and analytical support.

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

Detailed 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.

Members of the public spoke with us at our open days held at the trust on 4 May 2016.

We held focus group discussions with separate groups of staff during the week 2 May 2016. Participants included; allied health professional, administration and clerical staff, band 5 and 6 nurses, senior sisters and charge nurses, matrons and clinical nurse specialists. Focus group discussions were held with consultants, junior doctors and members of staff at different grades from black and ethnic minorities during the inspection week.

Our announced inspection visit took place over the 9 – 13 May 2016. We also undertook an unannounced inspection on 23 May 2016.

During our inspection we spoke with over 60 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 140 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 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.

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.

Facts and data about Moorfields Eye Hospital

Moorfields Eye Hospital City Road treats local patients and patients referred from other parts of England for treatment, patients participating in clinical trials and private patients. The lead commissioner is Islington Clinical Commissioning Group.

The hospital provides a range of diagnostic and treatment services, urgent and emergency services, surgery and services for children and young people.

Activity

Between Apr 2015 and Mar 2016 the hospital had 16,722 surgical spells, 292,254 outpatient attendances and 103,926 accident and emergency attendances.

Key intelligence indicators

Most of the following information was produced at trust level only.

Safety

- Eight serious incidents were reported at City Road between March 2015 and February 2016, including 3 treatment delays and one surgical error.
- Between October 2015 and end of January 2016 ,821 incidents were reported, of which the majority were either no harm, low or moderate harm.
- In terms of medical staffing skill mix: 39% are consultants which is line with the England average.

Effective

- The ratio of new to follow up outpatient appointments were slightly higher compared with other trusts**.**
- Best-corrected visual acuity (BCVA) results from Sept – November 2015 demonstrated that 91.2% of patients had a post-surgery BCVA of 6/12 or better. This is better than the national ophthalmology database audit result of 89% of patients who had a BCVA of 6/12 or better.

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- The trust had good outcomes for primary retinal detachment surgery. Against the national standard the trust reported a success rate of 88%, which is better than the national standard of 75% or more.

Caring

- In the 2014 CQC children and young people survey the trust scored the same or better when compared with other trusts for all of the questions. For the questions about the child's overall experience and the parent's view of the child's overall experience the trust scored better than most other trusts who took part in the survey.
- In the 2014 CQC accident and emergency (A&E) survey the trust scored better or about the same as other trusts who took part in the survey. For two questions, waiting to be examined and pain control they scored worse than other trusts. They scored better than other trusts in the question about the patient's overall A&E experience

Responsive

- The hospital received 111 complaints for March 2015 to February 2016.
- The bed occupancy has been consistently below the national average since.
- All 92 reported days of delayed transfer of care at the trust between April 2013 and August 2015 were accounted for by one of three categories, 'awaiting care package in own home' (40.2%) 'waiting further NHS non-acute care (33.7%) and 'Awaiting Nursing Home Placement (26.1%).
- Good performance on two week waits from urgent GP referral and also 31 day waits from diagnosis to first definitive treatment.
- Good performance on diagnostic waiting times with no patients waiting more than six weeks for diagnosis.

Well-led

- The overall response rate for the Department of Health 2015 Staff Survey was below other trusts: 40 % compared with 45%. Areas of good performance in the survey were staff satisfaction with quality of care they can deliver, staff motivation, the quality of appraisals and communication and recognition from management, team working and support. Areas where trust performed less well than other trusts included questions relating to violence, harassment and bullying from patients and staff, as well as discrimination and provision of equal opportunities for all staff.
- The trust scored better than expected for access to educational opportunities in the 2015 GMC survey.

Inspection history

This is the first comprehensive inspection of Moorfields Eye Hospital City Road.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	☆ Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	☆ Outstanding	Good	Good	Good

Notes

Urgent and emergency services

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

Information about the service

The Accident and Emergency Department (A&E) at Moorfields Eye Hospital, City Road is a single speciality department providing emergency ophthalmic care 24 hours a day, seven days a week. The department saw 102,482 patients between January 2015 and December 2015.

2,997 children and young people attended the main A&E out of hours. Between 9am and 4pm Monday to Friday, children and young people were treated at the Richard Desmond Children's Eye Centre.

The trust offers a dedicated telephone advice line to patients, GPs and other units. In addition, the trust recently introduced a consultant-led, optometrist delivered urgent care clinic.

Patients present to the department by walking into the reception area. On rare occasions, patients arrive by ambulance. A triage nurse assesses patients and assigns them to one of three categories based on the urgency of their condition. For patients with less urgent conditions, an emergency nurse practitioner sees patients using a 'see and treat' procedure. Priority is given to children and patients who are unwell. Staff also prioritise patients with possible infectious eye conditions who are treated in a separate area.

The A&E consists of a clinical decision unit (CDU), two triage cubicles, 20 cubicles, a treatment room, an isolation treatment room (red room), a consultant room and a paediatric consulting room.

We visited the A&E over three weekdays during our announced inspection. We also visited the department in the evening to see how the service operated outside the hours of 9am – 5pm. We observed care and treatment and looked at 13 patient records. We spoke to 32 members of staff including doctors, consultants, nurses, health care assistants, administrative staff and domestic staff. We also spoke with 15 patients and relatives who were using the service at the time of our inspection.

Urgent and emergency services

Summary of findings

Overall we rated the accident and emergency department at Moorfields Eye Hospital, City Road as good because:

- There were effective systems in place to protect patients from harm and a good incident reporting culture. Learnings from incident investigations were disseminated to staff in a timely fashion. The environment was clean and staff complied with infection control guidelines. Staff had received training in relation to safeguarding adults and children from abuse and they were clear about their responsibilities.
- An experienced team of ophthalmologists and ophthalmic trained nurses delivered care and treatment based on a range of best practice guidance. The unit had input from a multidisciplinary team.
- The Accident and Emergency Department (A&E) provided a caring, kind and compassionate service, which involved patients in their care. Patients had access to services for emotional and psychological support.
- There were clear care pathways that eased the flow of patients within the department and the department had fewer unplanned re-attendances when compared with the England average. The A&E had consistently achieved the national quality standard for seeing 95% of patients in less than four hours despite increasing demand on the service.
- There were systems in place for identifying patients with complex needs, such as dementia and learning disabilities, and responding to their needs.
- The leadership team had a clear vision and strategy and staff were able to verbalise future plans. The clinical leadership team had implemented quality improvement projects to deal with the increasing demand on the service.

However, we found a number of areas that require improvement:

- The paediatric waiting area was very small and unsuitable to meet the needs of children out of hours.
- Other people could overhear consultations with patients due to limited spacing between cubicles.
- Air conditioning in the department was unreliable and we noted excessive levels of heat in the waiting areas.
- The administrative office/records room was overcrowded with boxes, which presented trip hazards and a barrier to evacuation.

Urgent and emergency services

Are urgent and emergency services safe?

Good

We rated safe as good because:

- There were effective systems in place to protect patients from harm and a good incident reporting culture. Learning from incident investigations were disseminated to staff in a timely fashion.
- The environment and equipment was clean and staff complied with infection prevention and control guidelines. Staff had access to a wide range of equipment and all equipment were adequately maintained.
- Staff had achieved the trust target for most of the mandatory training modules.
- Patient records were comprehensive, with all appropriate risk assessments completed.
- Medicines were generally stored safely and securely.
- There were effective arrangements in place for safeguarding vulnerable adults and children.

However:

- There was a lack of storage space for patients' notes and the records room was overcrowded with boxes, which presented trip hazards and a barrier to evacuation.

Incidents

- Staff reported incidents on an electronic system and all the staff we spoke with during the inspection knew how to report an incident. Staff told us they received feedback and learning from incidents, including those that occurred in other units in the hospital. Senior staff shared trends or lessons learned from incidents during handovers and at staff meetings.
- All the staff we spoke with said they were supported and encouraged to raise any concerns with clinical and nursing leads.
- Staff reported 114 incidents between October 2015 and January 2016. Of these incidents, 104 resulted in no harm, seven resulted in minor harm, one resulted in moderate harm and one was classified as a near miss. One resulted in major harm and was investigated under the serious incidents framework.
- The serious incident was in relation to a delay in diagnosis of an eye infection. The investigation report was not yet available at the time of our inspection. However, the trust provided us with an investigation report for a serious incident that occurred during the previous reporting period.
- We reviewed the serious incident from August 2015. This was in relation to a delay in diagnosis of an eye infection. The patient was seen in A&E out of hours following a referral from their local hospital with a diagnosis of possible Herpes Simplex Virus (HSV). The patient was treated for HSV keratitis with uveitis and follow up was arranged with their local hospital. The patient's vision continued to deteriorate until they were re-referred to the trust in October 2015. A diagnosis of acanthamoeba keratitis was made and the patient was treated.
- The incident was fully investigated using the serious incident framework and an action plan was developed as a result. The investigation team recommended the need to remind staff of best practice in treating cases of presumed/suspected acanthamoeba keratitis. It also recommended the need to review the corneal and A&E handbook regarding the diagnosis and treatment of acanthamoeba keratitis in contact lens wearers and contraindications for HSV keratitis in contact lens wearers. The department had developed 'emergency guidelines at a glance'. The guideline advised clinicians never to diagnose HSV keratitis in contact lens wearers until they have excluded acanthamoeba.
- Nursing and medical staff were familiar with the duty of candour and were able to explain what this meant in practice. They identified the need to be honest about any mistakes made, offer an apology, and provide support to an affected patient. They provided examples of where they had adhered to this duty and demonstrated this in written letters to patient and their relatives.

Cleanliness, infection control and hygiene

Urgent and emergency services

- The accident and emergency department was visibly clean including the waiting areas, treatment rooms and cubicles. All the patients we spoke with were satisfied with the cleanliness. The toilets were sometimes untidy due to frequent use. However, we observed domestic staff cleaning the toilets frequently.
- Cleaning staff understood cleaning frequency and standards. They said they received appropriate training required for the role and were supported by the domestic supervisor. Cleaning schedules were displayed in the toilets.
- Cleanliness in the department was measured against the National Specification for Cleaning. Between April 2015 and January 2016, average cleanliness compliance was 92%. This was below the trust target of 95%.
- Infection prevention and control (IPC) lead staff undertook monthly hand hygiene audits based on the standards of the World Health Organisation's 'five moments to hand hygiene'. Between April 2015 and January 2016, average hand hygiene compliance was 95%.
- Antibacterial hand gel was available in waiting areas, clinic rooms, entrances and exits. Although high-visibility visual images indicated to people where they were, there were no printed instructions to encourage use.
- Basic personal protective equipment (PPE), such as gloves, were available in treatment rooms and cubicles. In addition, cubicles and treatment rooms had adequate hand washing facilities. The 'bare below the elbows' policy was observed by all staff. Disposable curtains in the cubicles and treatment rooms were labelled with the date they were last changed. This date was within the last one month of our inspection.
- A separate waiting area and isolation treatment room was available for patients presenting with possible cross-infection risk.
- The department conducted a sharps bin safety audit in November 2015. The department achieved 98.5% compliance, which is above the trust's target of 95%.
- IPC lead staff also conducted trust wide audits for slit lamp decontamination, patient toilets audit, curtain and blinds audit, linen and laundry audits and venflon insertion audit. The trust achieved 93% to 97% compliance in these audits against the target of 85%.
- All 52 nursing staff and 22 medical staff had received training in infection prevention and control level one. 90% (19 out of 21) administrative and clerical staff had received training in infection control level one. 88% (46 out of 52) nursing staff and 81% (18 out of 21) medical staff had received training in infection control level two. The trust wide target for infection control was 80%.
- The trust had no reported cases of methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (C.diff) in the year prior to our inspection.
- There were no reported cases of unit-acquired post-operative endophthalmitis in A&E in the last year. However, six cases of health care associated conjunctivitis adenovirus were identified in patients who had a previous visit to the department.

Environment and equipment

- The A&E had a separate emergency only entrance from the rest of the hospital. There were two triage cubicles near the reception area. There were 20 cubicles, a treatment room, a consulting room, the clinical decision unit (CDU) and an isolation treatment room called the 'red room'.
- There were separate waiting areas for patients at the reception, patients waiting to be triaged, patients on the nurse pathway and patients on the medical pathway. The sitting arrangements made it easy for patients to navigate the pathways, however, staff said they sometimes ran out of seats for patients due to limited space in the department.
- There was a separate waiting area for children attending A&E out of hours. There was direct access from the waiting area to the paediatric consulting room. The paediatric waiting area and consulting room had bright wall decorations.
- However, the socket outlets in the paediatric waiting area were not protected, with a potential risk of electrocution to children. In addition, we observed the

waiting area was adjacent to a utility room, which contained potentially hazardous substances. This room was left unlocked. We raised this with senior staff and they told us they would act on it.

- The records room was also used as an administrative office. This environment presented safety risks to staff. For example, it was overcrowded and boxes presented trip hazards and a barrier to evacuation. The room could not be adequately temperature controlled and staff had submitted incident reports in relation to ill health as a result of the environment. This included breathing difficulties due to the lack of natural airflow.
- The service manager had escalated the fire, and health and safety risk presented by the administration office to the trust executive team. This was also on the A&E risk register and there were plans to scan patient cards and to relaunch a business case for funding.
- Reception desks and clinical areas were fitted with panic alarms, which were connected to the medical emergency response team and the security team. A security officer was posted in the department overnight from 10pm to 7am, and access was controlled. All the staff we spoke with said they felt secure in the unit and the service provided by the security team was effective.
- The department had a wide range of specialist equipment, which was clean and well maintained. Labels were used to indicate when equipment had been reviewed for safety; however, they were not used to indicate when items of equipment had been cleaned. All equipment had undergone a safety check in the last year.
- A member of staff documented daily calibration checks on each tonometer (equipment used to measure the internal pressure of the eye). Staff completed this consistently and without gaps in recording.
- We observed resuscitation equipment was readily available and kept in the clinical decisions unit (CDU). Staff maintained a reliable and documented programme of checks including portable appliance testing (PAT). Nursing staff in the emergency department maintained resuscitation equipment with daily documented checks.
- Staff reported good access to technical support when there were problems with equipment. An on-site medical equipment technician was available Monday to Friday and on-call out of hours. The team provided support to clinical staff in training with specific items of equipment, including through ad-hoc instruction and competency checks.

Medicines

- Medicines cupboards were labelled clearly detailing contents within. We found medicines used for resuscitation and other medical emergencies were available, accessible for immediate use and tamperproof. There were weekly checks carried out on the monitoring of these medicines.
- Fridge and room temperatures were monitored on a daily basis, and staff were aware of the actions to take if there was a temperature excursion. We saw evidence of the recording of this on the logging sheets.
- The nurse in charge held keys to the controlled drugs (CD) cupboards. Staff audited controlled drugs on a daily basis and documented their audits in the CD register.
- 'To take out' (TTO) medicines were stored appropriately in a lockable medicines cabinet. Trust data showed that TTO times to pick up medicines were within the trust target of 20 minutes.
- Medicines for internal and external use were stored separately; along with small quantities of bulk fluids which were stored in the emergency drugs cupboard on the ward. However, the majority of bulk fluids were stored in the main pharmacy dispensary.
- We found that controlled stationary (such as stock order books and controlled drug registers) were stored securely and there were arrangements in place to monitor their use.
- Staff had access to the British National Formulary (BNF) as well as all policies/information relating to medicines management including the antimicrobial formulary. We saw a specific policy for the reduction of expiry dates for certain single dose ophthalmic medicines once they had been opened. We saw evidence from staff that they had implemented this policy successfully within the department.

- We saw the allergy statuses of patients were routinely recorded on medicines charts (both electronic and paper format).
- Staff understood how to recognise and report medicines safety incidents. Staff were aware of the dissemination of learning from these incidents, including by email and through a dedicated nurse in charge of medicines management in the department.
- The department was not staffed by a dedicated pharmacist all the time. However, nursing staff said they felt assured that they could seek advice about medicines from the pharmacy whenever they wanted, including out of hours.
- We saw staff training had been provided on the safe use and handling of medicines, along with competency assessments for prescribing, dispensing and administering medicines including under a Patient Group Direction.
- 96% (50 out of 52) nursing staff had completed the medicines awareness training against the trust's target of 80%. 96% (21 out of 22) medical staff had completed the prescribing practice and formulary for medical prescribers training. All nurse prescribers had completed the prescribing practice and formulary for non-medical prescribers.

Records

- Reception staff generated paper-based records when registering patients on arrival to the department.
- We looked at a random sample of 16 patient notes including three paediatric patient notes. All the records we reviewed were complete, legible and up to date. Staff recorded the time of arrival, time seen by triage nurse and time seen by the doctor or emergency nurse practitioner (ENP). Triage staff recorded allergies, pain score and patient priority. Staff recorded the examination carried out, diagnosis and treatment provided. Each record contained a copy of the discharge letter to the GP providing details of diagnosis, investigations, treatments, prescriptions and outcome. All the records were signed and dated by staff.
- Staff completed a child protection assessment for every child who presented in the department for the first time. They used this process to identify children with unexplained injuries or children who attended the department frequently. Records of paediatric patients seen in A&E out of hours were reviewed by a paediatric consultant the following day. The paediatric consultant reviewed the notes for appropriate diagnosis and treatment, request for follow up review where necessary and relevant investigations required. Our review of paediatric patient notes showed that each file contained a sheet called a scrutiny sheet. This was signed off by a paediatric consultant to indicate that the appropriate investigations had been carried out.
- Staff demonstrated a good understanding of the need for confidentiality and we observed the records room was secure.
- All (52) nursing staff, all (five) additional clinical staff (for example, health care assistants), 95% (20 out of 21) administrative staff, and 92% (20 out of 22) of medical staff had completed information governance training against the trust's target of 95%.
- A dedicated audit team conducted a monthly audit of patient records. Between April 2015 and January 2016, the department achieved over 95% compliance for the recording of relevant information. These included recording of NHS numbers, ethnicity, commissioner codes and source of referral, diagnosis codes, treatment codes and time seen for treatment.

Safeguarding

- There were appropriate systems and processes in place for safeguarding patients from abuse. Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- The hospital had dedicated child safeguarding and adult safeguarding leads that could provide rapid support to A&E staff on demand.
- A safeguarding policy and a safeguarding children and child protection policy was in place and staff were aware of how to access these.
- Where children presented in the main A&E out of hours, a nurse completed their initial visual acuity checks instead of a healthcare assistant (HCA). This strategy ensured staff with a higher level of child safeguarding training cared for children.

Urgent and emergency services

- All of the staff we spoke with demonstrated good awareness of child protection issues. For example, a member of the administration team told us the action they would take if an adult attended the department who was under the influence of alcohol or who behaved erratically and had a child with them. This action was proportionate and met the hospital's safeguarding policy.
- Staff completed a child protection assessment for every child who presented in the department for the first time. They used this process to identify children with unexplained injuries or children who presented at the department frequently.
- Staff demonstrated a proactive approach to supporting frequent attendees to the department and who were in need of safeguarding. The team discussed the top 50 most frequent attendees at monthly service meetings and identified patients who might benefit from a psychiatric or safeguarding referral. For example, staff noted one patient attended the unit on a monthly basis when they could be treated more effectively in a community setting. The service manager liaised with a local authority safeguarding team to ensure this person was appropriately supported. In another instance, staff noticed one person significantly change their outward appearance to gain access to the department. They liaised with the local authority safeguarding team to ensure the patient received the most appropriate care.
- All additional clinical staff, 95% (21 out of 22) medical staff, 94% (49 out of 52) nursing staff and 81% (17 out of 21) administrative staff had completed safeguarding adults training against the trust-wide target of 80%.
- All administrative staff had completed safeguarding children level one training. All additional clinical staff and 95% (21 out of 22) medical staff had completed both safeguarding children level one and level two training. 92% (48 out of 52) nursing staff had completed safeguarding children level one training and 90% (47 out of 52) had completed level two training.

Mandatory training

- Two dedicated nurses managed mandatory training, including annual refreshers and training for new staff. Over 86% of A&E staff achieved the trust target (of 80%) for all mandatory training modules.
- Staff undertook conflict resolution as part of their mandatory training, which enabled them to work effectively with people who presented with challenging behaviour as well as protect themselves from harm.
- Mandatory training included adult and paediatric life support, medicines awareness, safeguarding, mental capacity act, counter fraud, display screen equipment, equality and diversity, fire safety, infection prevention and control, information governance, moving and handling and medical gas safety. The trust offered basic life support and intermediate life support training on a monthly basis to ensure staff had the opportunity to be up to date with this training.
- Staff spoke highly of their opportunities for training and said it enabled them to keep up to date with best practice.

Assessing and responding to patient risk

- Experienced ophthalmic-trained nurses carried out triage. Triage nurses assessed patients and assigned them to one of two pathways: the medical pathway and the ENP pathway.
- The medical pathway consisted of three categories: priority 1 red indicating the most urgent conditions, priority 2 red indicating urgent conditions and a green category for less-urgent conditions. Patients on the ENP pathway (also referred to as 'see and treat') were patients who had conditions that could be assessed, diagnosed and treated by ENPs without the need to be seen by medical staff.
- Patients allocated to the medical pathway were first seen and assessed by nurses who took their medical history, checked visual acuity, carried out tests and investigations and evaluated the outcome of their assessment.
- Our review of 16 patient records showed that all the notes were marked with a triage category.
- Other factors influenced the patients' pathway through the department. Patients that required rapid

assessment and treatment had a 'brought forward' category recorded in their notes with the reasons why they required rapid assessment. They also had a 'brought forward' card attached to their notes for identification purposes. Patients brought forward included children, patients with dementia, patients with learning disability, patients with mental health issues and patients who were unwell.

- Patients suspected of having viral conjunctivitis or infectious conditions were also brought forward and asked to wait in the designated infectious waiting area. These patients were seen and assessed in the 'red room'.
- Patients who required extensive treatment, investigations and ongoing review were transferred to the CDU before they were either discharged or admitted. Patients brought to the department for observation and monitoring of general health problems were also admitted to the CDU before discharge or transfer to a general hospital.
- Senior staff told us that only patients with ophthalmic diseases were treated at the trust. However, on rare occasions, patients presented in the A&E seeking treatment for general health problems or patients who presented with an ophthalmic problem became acutely unwell due to a general health problem. Patients who presented with potentially serious life threatening conditions were assessed by medical and nursing staff, stabilised where possible and kept under observation while arrangements were made to transfer them via an ambulance to the nearest general emergency department for care and treatment.
- Staff used the National Early Warning Scores system to identify patients whose condition was deteriorating. Doctors in the ED were part of the on-call medical rota used to provide emergency care to the patients. This meant sick patients had rapid access to appropriate medical professionals when they needed it.

Nursing staffing

- As a consultant led single speciality ophthalmic A&E, there was no specific acuity tool in used in the department.
- Staffing levels on the pathways were based on the number of attendances and assessments and interventions required.
- A matron led the nursing staff and worked clinically as an emergency nurse practitioner (ENP) or co-ordinator. A Band 7 nurse coordinator supervised the pathways, patient flow and liaised with the multidisciplinary team. Two triage nurses assessed patients presenting with ophthalmic conditions and allocated them to the pathways.
- A team of 11 to 15 nurses cared for patients in the department from 8am to 9pm, seven days a week. There were five Band 6 nurses and four Band 5 nurses on the medical pathway. Three ENPs, one nurse training as an ENP and two health care assistants (HCAs) were allocated to the ENP pathway. Five nurses cared for patients out of hours from 9pm to 8am.
- A team of HCAs supplemented nurse staff levels and provided clinical support in assessing visual acuity and visual fields.
- A nurse handover took place twice daily. We observed two handovers and noted they were primarily for the nurse in charge of each shift. Staff discussed urgent concerns in the department such as failed air conditioning or access and flow breaches. However, handovers did not include interaction or engagement with all staff and there was limited evidence senior nurses considered staff skill mix when allocating tasks. For example, during one handover, several junior nurses arrived late when the handover had already started. They did not contribute to the handover and the nurse in charge did not speak to them. In addition, the nurse in charge checked attendance after the handover because they did not know if all planned staff were present.
- In March 2016, there were 49.88 whole time equivalent (WTE) nurses and emergency nurse practitioners in A&E. This was above the established level of 49.03 nurses required. The risk register indicated there were insufficient staff numbers to manage patients and safely cover the department due to increasing demand on the service, sickness and maternity leave. The service mitigated this risk by nursing staff working overtime and by increasing the use of bank staff. The department received support from the human

resources (HR) team to speed up the recruitment process for permanent posts. Temporary staff were required to complete a competency-based assessment to work on the unit.

Medical staffing

- An integrated team of 10 consultants and 42 registrars and fellows worked in A&E.
- There were seven to eight medical staff per shift. At least two consultants provided cover during the week from 8.30am to 5pm. Fellows and specialist registrars (SpRs) covered the evening shifts from 5pm to 11pm. A SpR covered the night shift from 9pm to 9am.
- On Saturdays, a consultant provided cover from 10am to 4pm. SpRs covered three 12-hour shifts (8am to 8pm or 9am to 9pm) and one six-hour shift as part of the rota. All other shifts were led by locum doctors.
- There was no consultant presence in the emergency department on Sundays. SpRs covered three 12 hours shifts (8am-8pm or 9am-9pm) and one 6-hour shift as part of the rota. All other shifts were led by locum doctors.
- Consultants provided on call cover for 24-hours a day, seven days. All weekend and out of hours paediatric activity took place in the main A&E and was covered by an on-call paediatric consultant.
- There was a heavy reliance on locums to cover evening and weekend shifts. However, all locum medical staff had previously worked at the trust. Before working unsupervised, locum doctors had three supervised sessions with the clinical service director and a consultant. This system ensured they had the necessary skills and competencies to work in A&E.
- Some senior staff told us weekend medical cover was sometimes problematic because of the absence of senior medical staff. The service manager had implemented a new Saturday shift for a senior locum doctor who was almost at consultant grade. A pilot of this approach had been successful and the manager was planning to implement a similar model of medical care on a Sunday.
- The leadership team had increased the numbers of doctors available per shift to meet increased demand. This included two junior doctors who worked until 11pm each evening and more medical cover overnight. This team demonstrated a proactive approach to increasing medical staffing during times of peak demand. As locum doctors routinely worked in A&E from across the hospital, managers could identify areas with low demand with an experienced A&E doctor who could temporarily support the department.
- Two GPs with an interest in emergency medicine were based in the unit, which had increased the number of doctors available to see walk-in patients.

Major incident awareness and training

- There was an up to date major incident plan for the trust with action cards in place for dealing with major incidents. These included procedures for dealing with hazardous materials incidents and chemical biological, radiological and nuclear defence.
- We reviewed training records which showed that staff had attended incident management training and business continuity training.
- None of the junior staff we spoke with were aware of the major incident plan or their role in the major incidence response.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good because:

- An experienced team of ophthalmologists and ophthalmic trained nurses delivered care and treatment based on a range of best practice guidance.
- Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. Medical staff received regular training as well as support from consultants.

- There was a programme of local audits in place and the results were regularly reviewed and fed back to staff.
- Staff managed pain relief effectively and the unit had input from a multidisciplinary team.
- The department had fewer unplanned re-attendances compared with the England average.

Evidence-based care and treatment

- Staff followed policies and procedures in line with current best practice guidance including the National Institute for Health Care Excellence (NICE) and the Royal College of Ophthalmology guidelines.
- Guidelines were easily accessible on the trust's intranet. There were processes in place for developing, approving, implementing and auditing guidelines. Staff were able to demonstrate ease of access and found them clear and easy to use. Paper based copies of the guidelines were kept in the matron's office.
- The accident and emergency (A&E) handbook for clinical staff provided clear best practice guidelines to ensure effective patient care. This provided guidance to staff for the management of ophthalmic conditions and the protocols for referral to other departments within the trust. For example, the protocol for referral to the medical retina clinics provided guidance on the referral categories of patients to the clinics. Medical staff could refer patients with eye threatening conditions to the clinics immediately.
- There was also a clinical guideline for paediatric ophthalmic patients. Staff used this in conjunction with the accident and emergency handbook – paediatrics. This provided guidance to staff on the treatment of paediatric ophthalmic conditions, triage process for paediatric patients, Wong-Baker Faces pain rating scale, paediatric escalation flow chart and guidance for clerical and nursing staff when children/ young people arrive by ambulance.
- Staff used resuscitation algorithms for adult and paediatric patients on the information board within the clinical decision unit (CDU).
- Clinicians and managers contributed to the British Emergency Eye Care Society, which had been set up to recognise emergency eye care in ophthalmology. This meant resident staff could contribute to developing practice in line with national benchmarks and guidance. Membership of the group had resulted in the creation of a number of clinical fellowships, which provided specialist training for junior doctors.
- A dedicated audit team provided the leadership team with monthly audit data, such as on patient records and admission information. This structure had resulted in specialist training for administration staff on techniques to ask patients for sensitive audit data, such as their ethnic background. Monthly audits had also resulted in 100% compliance with the recording of each patient's NHS number.

Pain relief

- We observed staff assess patients' pain on arrival to the A&E. Our review of patient records showed that staff recorded the patient score in patients' notes. Staff assessed pain in children using the Wong-Baker Faces pain rating scale. The scale showed a series of faces ranging from a happy face at zero: "no hurt" to a crying face at 10: "hurts worst". This allowed children to choose the face that best described how they were feeling.
- The department performed worse than other trusts for the question 'do you think hospital staff did everything they could to help control your pain?' in the 2014 A&E survey. Following the survey, the clinical leadership developed processes for staff to assess patients' pain.
- An audit of 99 patients' records who attended the A&E from 8 to 12 February 2016 showed that 99% of patients were asked about the presence of pain.

Patient outcomes

- As a single speciality ophthalmic emergency unit, the A&E did not participate in the Royal College of Emergency Medicine (RCEM) audits. However, there was trust-wide participation in the national ophthalmology database audit.
- Staff carried out monthly performance audits against national standards and the A&E at City Road performed above the national average for majority of the indicators for emergency services. Unplanned

re-attendances to the A&E were 0.4% between April 2015 and January 2016. This was better than the trust's target of 5% or less and better than the England average of 7.9%.

- One doctor had undertaken an audit of unplanned re-attendances of 500 patients seen by them between March 2015 and November 2015. A report was produced highlighting the initial diagnosis, management, reason for return and change in diagnosis for the eight patients who returned. For two of the patients, no change in management was necessary, however, six of the patients required further treatment after their condition worsened. The audit identified the need to tell patients to return if their symptoms worsen. A re-audit was planned for a future date in order to demonstrate improvement.
- An audit of 99 patients' records who attended the A&E from 8 to 12 February 2016 was carried out to determine the efficacy of the triage process for patients. All patients were triaged by senior nursing staff who were experienced ophthalmic trained nurses and were all signed off in their triage competency.
- The results showed that 99% of patients were asked about their reasons for attending, 97% of patients' duration of symptoms were documented and 99% were asked about the presence of pain. The results also showed that 81% of patients were allocated the appropriate triage category and 80% had the appropriate tests and investigations requested. Following the audit, an action plan was set out to reassess triage nurses' clinical competency by June 2016.
- The A&E undertook a number of quality improvement projects in October 2015 in order to improve patient outcomes. It put forward a business case for four immediate changes to service provision in support of the A&E. This included a proposal to implement 'active triage', to run general ophthalmology evening clinics, introduction of a nurse educator and reconfiguration of the administrative team to provide administrative cover between 7am and 10pm. This proposal had been implemented by the time of our inspection.

Competent staff

- A clinical education team provided training support and delivery to clinical staff. This included a lead nurse for education and a nurse practice educator (NPE). The NPE was a new post introduced to ensure the education provision for nurses was robust. As a result of the education team's work, all band seven nurses would be nurse prescribers and some band six nurses would be able to train to become nurse prescribers. The clinical education team tracked staff training and ensured clinical competencies were up to date.
- All band seven nurses and emergency nurse practitioners had passed clinical competency checks in the 12 months prior to our inspection. The NPE had improved this system by introducing practical supervised competency checks to replace the previous system of self-assessment. This ensured staff worked to national best practice guidance.
- Emergency nurse practitioners worked to specific competencies and protocols that enabled them to manage a triage stream of patients in line with their experience and skill mix. Practitioners were required to be able to carry out safe examination, diagnosis and instigate correct treatment for patients with a wide range of ophthalmic conditions. These included allergic conjunctivitis, arc eye, bacterial conjunctivitis, blepharitis, contact lens keratitis and corneal abrasion. Between April 2015 and January 2016, 30% of patients were seen on the emergency nurse practitioner pathway in line with the recommendation of the Royal College of Ophthalmology.
- Nurse prescribers were expected to have medicine skills equivalent to pharmacists, including knowledge of side effects and prescribing policies. The education team monitored nurse competencies in this area.
- All band seven nurses and all but two band six nurses had a post-registration ophthalmic qualification.
- The nurse educator had completed a nurse skills analysis audit in which nurses identified their own competency needs. This led to a restructure of the training programmes available and enabled the senior team to ensure staff had the specialist training they needed. This audit led to specialist training for two nurses in triage.
- New nurses went through an orientation programme to ensure they were familiar with local policies and procedures. They were allocated a mentor and received support from the practice development

team. They were also required to complete competency-based assessments before they were allowed to work without supervision. During this period the nurse responsible for mandatory training provided competency supervision during basic procedures such as taking eye swabs. This helped new staff to build their confidence and ensured their work was of a high standard.

- A team of healthcare assistants (HCAs) supported the nursing team. HCAs undertook an induction and seven day supernumerary period before they were able to work unsupervised. During this time, a nurse educator checked HCA confidence and competence through a series of clinical observations.
- HCAs had the option to take a three-month specialist training course after they completed their mandatory training. This course provided staff with the specific competencies needed to perform their role effectively and to continue their professional development. For example, on completion of training a doctor assessed HCA clinical competency in assessing visual acuity.
- Staff were trained in life support techniques based on their grade and level of responsibility. HCAs were trained in basic life support and paediatric basic life support. Nurses were trained in basic and intermediate life support.
- HCAs and band 5 nurses had access to an associate practitioner course, which would enable them to increase their clinical responsibilities. This formed part of a professional development plan from the education team.
- There were 10 consultant ophthalmologists in the department including the lead consultant. Junior doctors told us they were well supported and had access to weekly training sessions.
- At the time of the inspection, 98% of medical staff, 90% of nursing staff, 80% of allied staff and 95% of administrative staff had undergone an appraisal in the last year. The trust wide target for annual appraisals was 80%.
- A nurse educator completed pre-employment checks on agency staff to ensure they had appropriate ophthalmic skills to work safely in the department.

Multidisciplinary working

- Staff in the A&E worked closely with other services within the trust to provide an effectively co-ordinated service for patients. The A&E received support from specialist clinics, including clear pathways for referral for emergency sub-specialist care. A subspecialist consultant out of hours on-call rota provided senior support for all conditions.
- The A&E also liaised effectively with the Richard Desmond Children's Eye Centre (RDCEC) to provide follow up for children seen in the A&E out of hours. We saw that paediatric consultants reviewed paediatric patients' notes the following day after they were seen at the A&E. An on-call paediatric consultant cover was available in the A&E out of hours.
- A&E staff could refer non-emergency cases to the consultant-led urgent care evening clinic. We observed ophthalmic-trained nurses providing advice over a dedicated telephone advice line to patients, GPs and other units. These helped to reduce the flow of patients to the A&E as staff could direct patients with non-urgent conditions to the clinics or other services.
- Ophthalmic-trained nurses and emergency nurse practitioners worked effectively with medical staff to deliver care in the department. HCAs supported nurses to carry out visual fields tests.
- The department worked closely with other general emergency acute departments to refer patients who became acutely unwell whilst at the trust. Children were transferred to Great Osmond Street Hospital if they became acutely unwell because of other general health problems.
- The department maintained good working relationships with community teams. In particular, alcohol/substance misuse liaison teams and mental health teams.

Seven-day services

- Medical and nursing staff provided cover in the department 24-hours a day, seven days a week.
- A&E consultants provided on call cover for 24-hours a day, seven days a week. In addition, there was a rota of subspecialist consultants available 24-hours a day,

seven days a week. A&E doctors could contact them whenever they needed support or advice. Consultants attended the unit to review and manage patients as required.

- An on-call paediatric consultant covered all weekend and out of hours paediatric activity in the ED.
- There were no staff trained in advance paediatric life support (APLS) and adult advance life support out of hours. However, staff had immediate life support training (for both adult and paediatric patients) and there were clear guidelines in place to escalate the care of deteriorating patients.

Access to information

- The department had a computer system that showed how long patients had been waiting and their location within the department.
- Staff recorded patient registration details on the patient administration system (PAS). On completion of registration, all patients were provided with an A&E record card which was passed on to the triage nurse to record initial assessments and the investigations required. Our review of patient notes showed that all clinical staff recorded their care and treatment using the same document.
- Policies and guidelines were available on the trust intranet and were generally up to date.
- There were sometimes difficulties accessing patient notes out of hours and on weekends leading to the use of temporary patient notes. However, we observed staff used a different coloured sheet for temporary notes and there were systems in place for administrative staff to reconcile the notes during the day.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity to consent to their care and treatment. We observed that well documented consent forms were completed where required.
- Staff had access to best practice guidance and local mental capacity policies on the unit. Medical and senior nursing staff were aware of their responsibilities under the Mental Capacity Act (2005). They were able to talk about the deprivation of liberty safeguards and how this would impact a patient on the unit. However, some of the junior staff we spoke with were not clear about their responsibilities under the act.
- Fifty per cent of medical staff had completed the recently introduced mental capacity act training at the time of the inspection against a target of 30%. There were no training records available for nursing and administrative staff. The trust informed us that mental capacity act was part of the safeguarding training.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- A&E staff provided a caring, kind and compassionate service, which involved patients in their care, and we received numerous positive comments from patients.
- Staff were aware of people's individual needs and considered these when providing care.
- Staff provided emotional support to patients and patients were able to access the hospital multi-faith chaplaincy services, when required. Patients also had access to the trust's counselling service and the eye clinic liaison office.
- Patients' feedback was sought and the latest Friends and Family Test results showed over 90% of patients would recommend the A&E.

Compassionate care

- Patient, family and friends' feedback was mostly positive. During all of our observations, we saw staff treat patients and visitors with warmth and care.
- We observed staff interactions with patients. Staff were courteous, professional and engaging and demonstrated compassion to all patients
- Patients said they felt safe in the unit and they were happy with the care provided. They said staff explained procedures and obtained their consent before conducting them.

Urgent and emergency services

- On arrival in the department, a 'meet and greet' member of staff gave each patient a Friends and Family Test form and encouraged them to complete it after their visit. The member of staff showed particular compassion towards patients when they first presented in the department. This helped reduce anxiety and provide reassurance.
- The results of the Friends and Family Test survey between August 2014 and December 2015 showed that over 90% of patients would recommend the department to their friends and family.
- The accident and emergency survey in 2014 indicated the trust performed 'better' compared with other trusts for 10 of the 24 questions relating to 'caring'. They received the same rating as other trusts for the remaining 14 questions.

Understanding and involvement of patients and those close to them

- Patients and relatives reported they were involved in their care and were given explanations about their treatment. Patients said staff introduced themselves before attending to them. They explained the procedure they were about to carry out and the risks were discussed.
- We observed a member of staff making hourly announcements in the waiting areas to update patients about waiting times. In addition, an information system in the reception area provided details of the average waiting time. All the patients we spoke with confirmed that they were regularly updated about the waiting times.

Emotional support

- Patients had access to two separate services for emotional and psychological support. This included the Moorfields' counselling service and a rehabilitation service offered by an eye clinic liaison officer (ECLO). The ECLO offered specialist support services for patients who were losing their sight.
- Emotional support was also provided by the multi-faith chaplaincy service within the hospital and patients could access representatives from various faith groups.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Good

We rated responsive as good because:

- The number of patients attending the department had risen by 15% in the previous two years. Staff told us the population served by the department had increased following the closure of other ophthalmic urgent services. The service was able to respond to the increased demand and had consistently achieved the national quality standard for seeing 95% of patients in less than four hours. The ED achieved this standard every month since August 2014.
- There were clear patient pathways that eased the flow of patients within the department. The department had implemented an 'active triage' system whereby patients with non-emergency conditions were referred to the urgent care clinic.
- Ophthalmic-trained nurses provided advice over a dedicated telephone advice line to patients, GP's and other units.
- Staff had access to communication aids and translators when needed, giving patients the opportunity to make decisions about their care and day to day tasks.
- There were systems in place for identifying patients with complex needs, such as dementia and learning disabilities, and responding to their needs. Staff prioritised children and patients with complex needs during the triage process.
- Senior staff dealt with complaints appropriately and shared learning with all staff.

However:

- The paediatric waiting area was unsuitable to meet the needs of children out of hours.

- There was a poor ventilation system in place, with the inability to control the temperature of the A&E environment. We noted excessive levels of heat in the waiting areas, which made the waiting areas uncomfortable for patients.
- We observed that other people could overhear consultations with patients due to limited spacing between cubicles.

Service planning and delivery to meet the needs of local people

- In response to increasing numbers of patients presenting in the A&E, the leadership team had recruited a member of staff to 'meet and greet' patients on their arrival to the department. This person welcomed patients and directed them to the correct waiting area. This helped to reduce the pressure placed on reception and clinical staff to direct patients and answer initial queries.
- The service manager had begun to work with local GP practices to educate them about the services provided by the A&E. This strategy was in place to prevent patients attending A&E when they could be treated more effectively by a routine referral from their GP. The service manager was planning to extend this method of educating local service providers by discussing the scope and remit of the A&E with commercial opticians. This was to ensure opticians referred patients appropriately and to ensure the most appropriate professional saw patients at their first presentation.
- A new consultant led urgent care clinic staffed by experienced optometrists was established for patients with long-term eye problems and who did not require emergency ophthalmic care. In the first two months of operation between December 2015 and January 2016, 81 patients were seen in this clinic.
- The trust operated a telephone helpline service called Moorfields Direct. Staffed by experienced ophthalmic-trained nurses, the helpline was open from 9am to 9pm, Monday to Friday and from 8.30am to 5pm on Saturdays. Nurses provided advice on ophthalmic conditions and they forwarded callers to appropriate services where necessary. The service received an average of 112 calls a day between April 2015 and March 2016. This helped to prevent unnecessary visits to the A&E as staff could direct patients with non-urgent conditions to the clinics or other services.

Meeting people's individual needs

- Patients attending Moorfields Eye Hospital on City Road have guidance from the nearest tube station in the form of a green line leading directly to hospital.
- Documents were available in large print format and when requested, leaflets were available in braille.
- The three largest ethnic minority groups within the local population were Turkish, Bengali and Polish. Leaflets were available on the computer systems in the three languages for print off if required. The trust provided a face-to-face and telephone interpreting service. The trust also provided a British sign language service.
- Staff reported they could access interpreting services for patients through a help line when required. However, face-to-face and British sign language services were booked in advance, and could be made available for patients attending a follow up appointment.
- Information on domestic violence services, including rapid self-referral organisations, was readily available and displayed on electronic information screens.
- The electronic patient records system enabled staff to highlight patients with dementia, learning disabilities, cancer and other specialist needs such as a language barrier. For example, a 'helping hand' symbol identified any patients who needed extra support whilst in the department. We observed that patients with complex needs had 'helping hand' stickers on their notes.
- We saw a copy of a patient passport for a patient with a learning disability. It was designed to be completed by patients or their relatives to identify information about the patient that staff needed to know, such as how they preferred to communicate, how they behaved when anxious or distressed, how they would tell staff if they were in pain and their support needs in aspects of daily living.

- Staff prioritised children and patients with complex needs during the triage process. This ensured they were not kept waiting for too long.
- Nurses were able to establish their own specialist interest roles, which the department named 'nurse champions'. Nurse champions were active in infection control, privacy and dignity, safeguarding, learning disabilities, dementia and medicine. This meant there were dedicated staff to develop specialist knowledge and services based on the individual needs of patients.
- Staff supported patients who were not able to communicate verbally, or those with a learning disability, with visual communication cards. For example, staff used these to explain a vision test to someone they were not able to speak with.
- A low sensitivity room was available for patients who were agitated or who needed to be seen by the psychiatric liaison team.
- Patients had access to a water dispenser and a vending machine in the A&E reception area. Patients also had access to a café within the trust.
- Clinical staff assessed patients in cramped cubicles and we could overhear consultations with patients. However, it was rare for patients to require physical examination in the A&E due to the nature of the specialised ophthalmic service offered. Staff had access to the clinical decision unit (CDU) or treatment room when required. Both rooms were away from the main cubicles and had doors that could be closed to ensure privacy for the patient.
- The facilities for children seen at the A&E out of hours were unsuitable to meet their needs. The paediatric area was very small and there was not enough room for children to play or move around freely. There were two toys available for younger children/toddlers and a plastic box which contained very few toys. There were no age appropriate activities for older children. We saw children waiting in the main waiting area. Staff told us children and young people tended to stay in the main waiting area
- Air conditioning in the department was unreliable and we noted excessive levels of heat in the waiting areas. Water coolers were available and the senior staff had tried to order some fans from the facilities team but these were not provided quickly. This made the waiting areas uncomfortable for patients.

Access and flow

- Between January 2015 and December 2015, 102,482 patients attended the A&E.
- Once registered, a triage nurse assessed patients attending the A&E. Patients with non-urgent conditions were either booked for an appointment to visit the urgent care clinic or advised to request a referral letter from their GP. Patients with urgent conditions were allocated to the medical or ENP pathway. Patients were then assessed, diagnosed, treated and discharged or admitted from the A&E.
- There were systems in place to prioritise patients with urgent ophthalmic conditions, paediatric patients and patients with complex needs.
- The senior leadership team used the results of a service review to implement a system of active triage to manage increased patient attendance and improve flow. This system enabled staff to refer patients to a new weekly evening clinic or back to their GPs for more appropriate non-emergency care.
- Staff in satellite clinics across the trust's network often referred patients to the A&E. Consultants assessed each referral to ensure it was appropriate. Where a patient could be treated more appropriately in a non-emergency setting, the consultant contacted the clinic directly to discuss the scope of the service available.
- Medical staff conducted a survey involving 798 patients to find out if they were willing to use satellite clinics closer to them. Of those surveyed, 50% said they would prefer to attend an urgent care service closer to them. The leadership team used this information to improve satellite clinic access.
- Performance against the accident and emergency maximum waiting times (four hour target) was 97.5% between April 2015 and January 2016. This was 99.2% in the previous year. This was better than the trust's

target of 95% and the England average. The A&E achieved 77.7% compliance against an additional internal three hour maximum wait target. This was below the trust target of 80%.

- The median total time in the department was better than the England average each month between August 2014 and December 2015.
- Between April 2015 and January 2016, 2.4% of patients left without being seen. This was also better than the trust's target of 5% or less.

Learning from complaints and concerns

- All the patient waiting areas had leaflets advertising the services of the Patient Advice and Liaison Service (PALS) and provided information about how to complain. Patients we spoke with were aware they could raise any issues with staff in the department or seek assistance from PALS if needed.
- Staff were aware of the action to take if someone raised a complaint or a concern with them and said they would escalate it to senior staff. They said patients would be encouraged to involve PALS where appropriate.
- The service manager took a proactive role in resolving complaints directly with people. For example, if a member of staff received a complaint from a patient or visitor, they immediately escalated this to the service manager who would meet the person for a discussion. The leadership team had oversight of a complaint investigation process that allocated the most appropriate senior person to resolve a complaint based on whether it was about the service or a member of staff.
- The service manager introduced a telephone simulation system to improve the call handling skills of administration staff. They used this system to assess staff responses in challenging situations and to improve the care provided to people who could not communicate easily. The service manager supplemented this system with random spot checks on staff communication during live calls. This helped to ensure reception staff provided a good service and reduced complaints relating to communication.
- The A&E received 20 complaints between March 2015 and February 2016. These were mostly in relation to staff attitude and delay in treatment. Complaints were investigated appropriately with feedback provided to the patient and staff involved.

Are urgent and emergency services well-led?

Good

We rated well led as good because:

- The leadership team had a clear vision and strategy and staff were able to verbalise future plans.
- We saw good local leadership within the department and staff reflected this in their conversations with us. Staff were supported in their role and had opportunities for training and development.
- The management team had oversight of the risks within the services and mitigating plans were in place.
- There was evidence of staff engagement and changes being made as a result.
- Patients were engaged through surveys and feedback forms.
- The clinical leadership team had implemented quality improvement projects to deal with the increasing demand on the service.

Vision and strategy for this service

- The clinical governance team had begun a transformation project to consider the best use of the A&E as an emergency 24-hour, seven days service. As part of this, the service manager was scheduled to visit other emergency departments to compare models of care and identify the most appropriate way to continue providing services.
- The leadership team had a clear focus on improving access and flow in the department to meet the demands associated with growing patient attendances. The clinical governance team had an immediate vision of replicating the model of a Wednesday urgent care clinic to a second weekday evening from June 2016. This would address the

significant number of patients who attended the department but did not need emergency treatment. Staff we spoke with were able to verbalise plans to deal with the increase in demand for emergency services.

Governance, risk management and quality measurement

- The A&E was under the outpatient and diagnostic directorate. A clinical director, general manager and a nurse manager led the service. A service director, service manager and matron led the emergency department.
- The service director, service manager, matron, nurse manager and administration manager formed the clinical governance and leadership team. This team met quarterly to discuss the department's performance and any breaches. This was a responsive strategy to address clinical risks associated with capacity and staffing issues.
- A dedicated team of senior staff formed a serious incident panel to investigate and consider learning from serious incidents. This was part of the overall risk management and clinical governance strategy and enabled staff to focus specifically on incidents.
- The clinical governance team managed a risk register, which included a review of all risks every six weeks. The risk register identified the environment and the rapid increase in patient attendances as the most significant risks to the service. This included the administration environment used to store patient notes and the paediatric area. The A&E plans to relaunch a business case for the introduction of an electronic document management (EDM) system and scanning all casualty cards. The 2014-2015 accident and emergency service review report identified an option to relocate the paediatric area to theatre 9. However, it is not clear when this review will be implemented.
- Senior staff had established a weekly urgent care clinic to address the increase in attendances. Clinicians referred patients to this as an alternative to their GP or optician which meant emergency cases could be seen immediately. The clinical governance team had audited this service during the initial phase and found 100% of patients were seen appropriately or safely. The senior team had communicated details of the clinic to local GPs to improve awareness of the emergency treatment nature of the department.

Leadership of service

- Staff told us they were supported by senior management in the A&E. They confirmed that senior management were approachable and visible in the department.
- There were clear lines of responsibility in the department and staff understood their roles and how to escalate problems.
- The leadership team offered staff flexibility in their rota to encourage a good work-life balance, such as if the member of staff had young children. Staff told us this worked well and helped them to perform more effectively.
- The chief operating officer attended the unit every weekday morning to check on staffing levels and performance in the unit. Staff told us this represented their good relationship with the executive team, including with the chief executive officer who held monthly briefings to which they were invited.

Culture within the service

- Staff at all levels told us there was a culture of support for continuing professional development and clinical supervision. For example, one member of staff said, "I can ask for extra training whenever I want. My line manager is very supportive of anything that makes us more confident."
- Nurse educators had an active relationship with the staff education and commissioning team, which helped them to obtain funding for specialist staff training.
- Most of the staff we spoke with told us about a positive working culture in which they felt valued and respected. One member of staff said, "When you come in every morning, everyone is happy to see you. It's a lovely feeling and makes me happy to come to work."
- The clinical leadership team had worked closely with human resources (HR) to establish an interview process for promoting staff and assessing new applicants that was fair and transparent. This was in

response to concerns about selection processes and allegation of discrimination in the department. A successful trial had taken place and the new process ensured a senior clinician who had a neutral relationship with the A&E was always present on the interview panel.

- We spoke with an HR advisor about this and they told us there were processes in place to address allegations of discrimination. The human resources team offered a confidential and anonymous reporting system for staff to use if they did not want to report a concern. The HR team had implemented a number of strategies to ensure staff felt safe and comfortable at work. Clinical staff were provided with specialist training on different types of discrimination, including how people from different cultures perceive each other. HR had also offered staff the chance to take part in a 'difficult conversations' course and personal awareness training. Both courses were designed to help staff from different cultural backgrounds improve their communication and understanding of each other. Equality and diversity training was included in all staff inductions, regardless of their role.

Public and staff engagement

- Administrative staff and the service manager had engaged patients to discuss how they could improve the triage process. This resulted in patients keeping the initial numbered ticket they were given so they knew their position in the queue to be triaged and a trial of an electronic number system in non-clinical areas. This meant patients had a better understanding of waiting times and ensured clinical staff were still able to prioritise people based on their level of need.
- The department monitored patient satisfaction from patient surveys, comments and feedback forms. Patient survey outcomes were used to improve the service. For example, feedback from patients regarding pain assessments were used to improve pain relief offered to patients.
- Nurse team leaders scheduled monthly team meetings and matched the schedule to staff rotas to ensure everyone could attend. Staff told us the meetings were worthwhile and they felt engaged with changes in the service and policies as a result.
- Staff had access to specific human resources advisors who could support them with any workplace issues or concerns. The trust had also trained a number of 'contact officers' who provided staff with the opportunity to talk in confidence with someone not connected with their department. Contact officers could provide emotional and professional support to staff without the need for them to speak to their line manager and acted as liaisons with human resources.
- A nurse educator had been appointed after the senior team identified nurses wanted a more robust system for training and professional development. This member of staff engaged all A&E nurses to identify their own gaps in knowledge or training needs as part of a skills analysis audit, which they used to provide a new training programme.
- Staff said they were recognised and encouraged for their hard work. Staff confirmed that they got regular thank you emails for their hard work.

Innovation, improvement and sustainability

- Service sustainability was a key priority of the leadership team to be able to meet the increasing demands on the service. The service manager and service director worked with colleagues across the trust to attract consultants who were about to leave their service to consider the A&E for their next post. This strategy also included the active recruitment of multidisciplinary fellows across the trust who may be interested in joining the A&E team in a substantive post.
- The leadership team used a 'space committee' to consider if the very busy and often cramped A&E environment could be reconfigured to make better use of the space. The committee engaged with staff and encouraged them to suggest innovative ideas for more efficient use of the space.
- The service manager had a schedule of visits to other emergency eye departments planned. This project was to consider how other hospitals dealt with eye emergencies and what this service could learn from them.
- A member of the senior team had visited another emergency eye department to explore how they cared

for patients with mental health needs. This had resulted in the provision of a dedicated low-sensitivity room in the department for patients with high levels of agitation or with mental health needs.

- The department recognised outstanding staff through an employee of the month scheme. The trust conducted an annual staff excellence awards event called the 'Moorfields stars' to celebrate outstanding staff and long service.

Surgery

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

Information about the service

Moorfields Eye Hospital City Road provides specialist elective and emergency eye surgery services for the local population and for those from further afield who require eye treatments not available elsewhere.

The surgical services directorate comprises all elements of the surgical patient pathway at the City Road site. The directorate is split into specialties of adnexal, cataract, corneal, theatres and anaesthesia, vitreoretinal, admissions, day case wards and pre assessment.

Between April 2015 and March 2016, there were 23,433 referrals to the surgical directorate at City Road. In 2015/16 the services performed over 14,000 operations, 96% of these were day case procedures. The largest surgical service at city road was the adnexal service, which received 6691 referrals.

There are nine operating theatres at the City Road hospital site. The main theatres suite is comprised of eight operating theatres, and is located on the first floor. Facilities include a dedicated adult and paediatric recovery area. Theatre nine is located within the emergency department where minor operations are carried out only. There are two, day surgery wards (Sedgwick and MacKellar) located on the first floor one for male patients and one for female patients. Day surgery patients are assessed, operated on and discharged within a day. The day surgery wards are a mix of beds and chairs, which can be utilised appropriately for patients who have either a local or a general anaesthetic. There is one observational ward on the fourth floor for patients needing to stay overnight for ophthalmic nursing care, with six side rooms. There is also a private ward (Cumberlege Wing) for private surgical patients, also located on the fourth floor.

During our inspection, we visited the surgical services on Tuesday 10, Wednesday 11 and Thursday 12 May 2016 and during an unannounced visit on Monday 23 May. We followed the patient journey from admission through operating theatres and immediate post-operative recovery, then on to the surgical wards and finally discharge.

We visited the surgical preassessment area, the surgical wards, main operating theatres including theatre nine and the adult and paediatric recovery area. In addition to this, we interviewed service leads and matron/managers of the services. We spoke with over 50 members of staff including managers, doctors, nurses, allied health professionals, health care assistants, support staff and administrative staff. We spoke with over 20 patients and their family members. We observed their care and treatment and looked at 12 care records. In addition to this, we reviewed local and national data and performance information about the service.

Surgery

Summary of findings

Overall we rated the surgical services at Moorfields Eye Hospital, City Road as good because:

- There was a low number of serious incidents. We found good processes for reporting incidents and systems in place for learning.
- Clinical areas were visibly clean and there was good compliance with hand hygiene processes resulting in low infection rates.
- Staffing levels were good based on regular acuity reviews with low vacancy rates across the service.
- There were good patient outcomes across surgical services and care was delivered in line with relevant national guidelines.
- The continuing development of staff skills, competence and knowledge is recognised as being integral to ensuring high quality care. Nurses and health care assistants felt well supported with good supervision and training opportunities.
- Staff across surgical services were friendly, caring and professional, and patients' feedback was overwhelmingly positive about the services.
- Patient flow from admission through theatres to the wards and discharge had improved through new ways of working.
- There was good staff awareness with systems and provision of care for patients with complex needs, such as those with learning disabilities and dementia.
- We found a cohesive and supportive leadership team, with well established members of staff. Matrons and ward managers were complimented on being visible and supportive.
- There were comprehensive and robust governance and risk management processes in place with appropriate systems to ensure information was shared.

However:

- The service was not using the World Health Organisation (WHO) surgical safety checklist in theatres and audit information and observations during inspection demonstrated that improvement was required.
- There was no formalised competency assessment process to ensure staff had the adequate skills and knowledge to care for paediatric patients in the recovery area of theatres.
- Mandatory training rates in some areas were below standards set by the trust and data demonstrated that 108 members of staff had not completed training in basic life support.

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- Improvement was required to fully embed the World Health Organisation (WHO) safer surgery checklist into practice. Audits demonstrated, and we observed, poor practice in the documentation, the quality of the process and staff engagement during the process.
- Mandatory training levels in some areas were below trust targets including resuscitation training which 108 staff within the surgical services needed to complete.
- Staff told us they did not always have the complete information they needed before providing care and treatment. Staff told us records for patients were not always available when required for patient assessments and procedures. There were still a number of temporary patient records in use and staff on the wards highlighted this as a concern.

However:

- The majority of staff knew the process of reporting and investigating incidents using the trust's electronic reporting system. Most staff understood and fulfilled their responsibilities to raise concerns and report incidents as well as near misses and were supported to do so.
- Records demonstrated that risk assessments were completed at each stage of the patient journey with the national early warning score system used to recognise and manage deteriorating patients. Policies were in place to respond to patients who required further care, which meant transferring the patient to other services.
- Adequate staffing levels and skills mix was a high priority and were planned, implemented and reviewed to keep people safe at all times. Minimal staff shortages were responded to by senior nurse leaders using internal bank staff and rarely agency staff.
- Safeguarding vulnerable adults was given sufficient priority by staff who were aware to ensure immediate safety and to discuss concerns.

Incidents

- There were 108 incidents reported within the four months from October 2015 – January 2016 within the surgery services at the City Road site. There was 1 incident at City Road that met serious incident (SI) criteria.
- Nineteen incidents related to medical devices and there were 9 incidents that involved sharp injuries to staff (7 in theatres and 2 on a day care ward). In response to this, we observed and were told about sharps safety improvements in the theatre department. These included surgical count training, training in handling techniques, introduction of safe zones on scrub trollies and the use of new blades.
- We looked at two incident reports. These included a detailed chronology of events and a thorough investigation and root cause analysis of the incident. They also included discussion of duty of candour, recommendations for immediate and future action and arrangements for sharing these recommendations, learning and actions locally and across the trust.
- Most staff across the surgery service were able to tell us how to report incidents however, there were two staff on Sedgwick ward who were unaware of the process. Other staff could identify situations requiring completion of an incident form and staff told us there was a good reporting culture where they were encouraged to report 'near miss' situations in addition to incidents that had occurred. Staff could identify learning which had occurred due to a never event which had happened recently within the trust however, had limited knowledge of recent incidents and learning which had occurred within their own departments.
- Ward managers communicated information to staff and ensured information was communicated in a timely manner rather than waiting for the next ward meeting. Staff informed us information about incidents and learning was shared at morning catch ups, Monday team meetings and at monthly wards meetings.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- Some staff had awareness in the process of duty of candour. Staff explained that patients should be informed an incident had occurred, informed of the investigation and given an apology. However, three staff members on MacKellar and Sedgwick wards were not able to describe this process in any detail.

Cleanliness, infection control and hygiene

- Infection prevention and control (IPC) was well managed within the surgical services. Clinical areas we visited were visibly clean, tidy, well organised and mostly clutter free. We observed staff washing their hands, using hand gel between patients and observed staff complying with the 'bare below the elbows' policy.
- Hand hygiene audits demonstrated surgical services were compliant with hand hygiene from April to June 2015, partially complaint July to December 2015 and compliant in January 2016. Partially complaint meant results of these audits were below 95% and attention was required. Hand hygiene audit results were displayed at the entrances to each department and during inspection these demonstrated all areas were compliant in April 2016 with results 95% or greater.
- There had been no cases of Meticillin resistant Staphylococcus Aureus (MRSA) or clostridium difficile for the 12 months prior to inspection
- Cleaning audits were carried out and demonstrated 98% and above compliance for the period April to June 2015. Domestic staff we spoke with told us they received regular feedback about these audits and were aware when improvements were needed.
- IPC nurses carried out venflon insertion audits to ensure practice was in line with trust guidelines. The most recent trust wide annual audit performed in September 2015 demonstrated hand hygiene before use (82%), integrity of sterile packs checked (82%), documented insertion of device (76%) and use of single use gloves (76%) scored below the compliance target of 85%. All other 9 categories examined scored well above the compliance target. However, there was no available re-audit of this.
- Possible hospital exposure to adenovirus was defined as any positive swab result up to 21 days post visiting the hospital. The surgical services demonstrated a continuous drop in infection rates over the previous three years and results demonstrated rates were below trust expected targets.
- The City Road surgical services reported nine cases of postoperative endophthalmitis (an inflammatory condition of the intraocular cavities) cases from January to December 2015. This is below the expected rate. These infections were reported regardless of whether the infection was hospital related or a suspected community acquired infection.
- There was a trust policy which outlined the patient cohorts who were to undergo presurgery MRSA screening. Data demonstrated that 100% of surgical patients requiring screening were screened for MRSA
- The IPC nurses undertook regular walkabouts in clinical areas, which included the inspection of patient equipment, the environment, sharps containers, waste bins and hand hygiene. Verbal feedback was given to staff immediately and a written report followed with any recommendations for improvement.
- IPC information was shared through a monthly newsletter called 'the bug brief', which is sent to all infection control link nurses highlighting current subjects of interest. We saw copies of 'the bug brief' in staff areas.

Environment and equipment

- Equipment in theatres and in ward areas was up to date and portable appliance tested (PAT) according to regulation.
- In theatres there was a daily checklist completed which included the checking of the equipment and the environment. The checks included the operating lights, microscopes, diathermy and temperatures and ventilation in the theatres.
- We saw adult and paediatric difficult airway equipment trollies available in the recovery areas. Staff in theatres told us that recovery staff were aware to check the contents of the trollies including expiry dates of equipment as part of the daily duties check. There was no separate checklist completed for the equipment

within these trollies to ensure all equipment was present and in date. When staff were asked how they ensured these were checked they were unable to locate any checklists.

- The theatre department used three different types of laser machines and therefore goggles were colour coded to identify which machine these were used for. Staff had received verbal training and there were no completed documentation tools to assess staff competency. There was a general laser risk assessment however these were not dated and staff were unsure when these had last been reviewed. Laser safety guidelines were available on the trust intranet however, these were dated October 1999 and had not been revised. After the inspection, up to date safety guidelines were provided however, staff were not aware of these and the old guidelines remained on the intranet.
- We saw resuscitation equipment available in all clinical areas with security tabs present and intact on each. We saw checklists completed daily with no omissions.
- Single use equipment such as syringes, needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner in the anaesthetic and recovery rooms.
- The minor operation theatre was located within the ED department and it was unclear to the inspection team and to staff which patients were waiting for a procedure and which patients were waiting to be seen in the ED.

Medicines

- Treatment rooms were clean and tidy in all areas we visited, with cupboards clearly labelled with details of the contents within.
- Keys to the medicine cupboards and patient own drugs (POD) lockers were held by registered nurses and doors to the rooms housing medicines were locked with restricted access.
- Small quantities of fluids were stored appropriately in the treatment room. However, the majority of bulk fluids were stored in the main pharmacy (outside the wards) which was appropriately locked.
- Controlled Drugs (CDs) were checked twice daily, with a separate signing sheet seen. CDs were correctly documented in the CD register, with access to them restricted to registered nurses who held the keys. We checked the controlled drugs on both Sedgwick and MacKeller wards and found that they were correctly counted and stored.
- Medicine trolleys were seen to be chained to the wall or immobilised to ensure they were secure when not in use. The medicines inside were appropriately locked by an electronic keypad. Medicines inside the trolley were in date and stored appropriately.
- Room and fridge temperatures were recorded on a daily basis and were found to be within the recommended range. When asked what would happen if the normal fridge temperature of two to eight degrees went out of range, the nurse stated that a member of clinical staff would be responsible for taking the appropriate action to rectify the anomaly, which included contacting the pharmacist and estates management.
- There was a policy in place to support the use of PODs and we saw evidence of green bags containing PODs, appropriately stored in lockers beside patient bays.
- Nursing staff stated they were happy with the pharmacy service received out of hours (evenings and weekends). They commended the support and advice received by the on call pharmacist.
- Staff had access to British National Formulary (BNFs) as well as all policies/information relating to medicines management (including the antimicrobial formulary) via the trust intranet.
- Dedicated induction processes provided by the trust, through the intranet, assessed staff competencies for prescribing, dispensing and administrating medicines. However, it was not clear how often nurses received regular training updates on a formal basis.
- Staff understood and demonstrated how to report medicines safety incidents. Learning from these incidents was then fed back through various channels, such as medicines safety newsletters, emails and monthly meetings from 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.

- Medicines related policies were available via the intranet including administration of medicines, antimicrobial prescribing and management, and patient group directions. All policies had been recently reviewed and clearly documented the next review date.

Records

- We looked at 12 samples of medical and nursing records on the day case surgical wards and in theatres. The hospital used mainly a paper based record system for recording care, treatment and surgical interventions and had a treatment paper record booklet for all surgical patients, which was used throughout the pathway. Nursing and medical records were accurate, fit for purpose, stored securely behind the nurses station and were mostly completed to a good standard.
- The patient assessment and treatment record had been designed to ensure all peri and post-operative information was kept in one place. This consisted of patient medical history, pre assessment information, Creutzfeldt-Jakob disease assessment, risk assessments, admission information, theatre checklist, observations, handover information, and discharge information.
- Assessment and treatment records we looked at were well completed including risk assessments for day case surgery patients. We saw one set of notes where the initial theatre checklist had not been completed fully however had been signed off by two nurses as being complete.
- The WHO surgical safety checklist is a system to safely record and manage each stage of a patients journey from the ward through the anaesthetic and operating theatre. We saw the checklist completed in most postoperative patient's notes however, two had not been signed or dated.
- We looked at twelve surgical consent forms across the department. All consent forms were signed and dated, and information was legible, however none of the patient copies had been given to patients or documented that it had been offered.
- Information governance was part of the mandatory training. Compliance rates were below the trust target of 95% across all of the surgical services. Data provided demonstrated that 83% of staff had completed this training.
- Temporary notes for patients' were created if notes were missing or not accessible during a patient's appointment. Temporary records were identifiable as these were in pink coloured folders. Staff identified that this was a risk when information was not available on the day of a patient's procedure. We were advised that only one operation had been cancelled throughout 2015/16 due to missing notes. In 2015/16, data demonstrated that 281 temporary notes were used due to missing patient's notes.
- In January 2015, an audit of 210 sets of notes found that five had not been tracked appropriately and therefore may be difficult to find prior to a patients appointment.
- There were ongoing projects to devise plans to improve the management of patient records. Senior staff were involved in regular meetings with the information governance and IT teams to propose and plan for moving to an IT based system however, these plans appeared to be in the very early stages and there was currently limited staff engagement and knowledge about this process.

Safeguarding

- Training figures provided demonstrated 88% of nurses and 92% of doctors within surgical services had completed safeguarding adult training against the trust target of 80%.
- In total 94% of all staff within surgical services had completed child safeguarding level 1 training. Ninety four per cent of nurses had completed level 2 training and 100% of medical staff had completed child safeguarding training up to level 3.
- The trust had a policy in place to safeguard vulnerable adults and children. This was readily available to staff on the intranet.
- Staff in theatres were clear about their role in safeguarding patients. Staff told us the importance of checking the correct consent form had been signed and discussed, ensuring patient understanding of the procedure.

- Nurses we spoke with demonstrated a good knowledge in relation to safeguarding triggers and types of abuse, and were confident when relaying the process to follow if they had concerns about the patients in their care.
- Each department had a safeguarding link nurse and posters were displayed to ensure staff could access help and advice when required.

Mandatory training

- Trust performance reports showed mandatory training completion results varied amongst the different staff groups. Training figures provided by the trust demonstrated an average compliance of mandatory training of 84% of nursing staff, 83% of medical staff and 76% of allied health professionals.
- Reports demonstrated varied completion rates for different training topics required. For example, 88% of staff had completed equality, diversity and human rights training, 84% had completed fire training and 67% had completed adult basic life support training meaning 108 members of staff were non compliant and needed to complete this training.
- Staff we spoke with felt they were up to date with mandatory training; and confirmed adequate time was given to them to attend relevant teaching and training sessions.

Assessing and responding to patient risk

- Patients' clinical observations were recorded and monitored in line with National Institute for Health and Care Excellence (NICE) guidance 'Acutely ill adults in hospital.' A scoring system known as a national early warning score (NEWS) was used to measure patients' vital signs and identify patients whose condition was at risk of deteriorating. We saw staff on the surgical wards and in recovery recording patient observations such as heart rate, respirations, blood pressure, temperature and pain.
- Regular audits were carried out to assess compliance of early warning scores (EWS) completion and demonstrated 100% adherence on both MacKellar and Sedgwick wards however, improvements were needed in the Cumberlege wing and an action plan had been submitted.
- Assessment tools were used for assessing and responding to patients' risks, and these were fully completed in patient's notes. For example, the Waterlow Pressure Ulcer Risk Assessment (2010), Venous Thromboembolism Tool (VTE) and Safer Skin Care (SSKIN) were all in use within the patient assessment and treatment record. This information was utilised to manage and promote safe patient care.
- In theatres, we saw the World Health Organisation (WHO) surgical safety checklist in use . During our observations we noticed that three steps were used. We observed the sign in, timeout and sign out process in a number of theatres however, we noted a time out taking place without the surgeon present and twice we noted sign out completed after the patient had left the theatre. Furthermore, we noticed staff distractions while the checklist was being completed and in one instance, it was unclear who was leading the time out process.
- A recent audit of the checklist had been carried out in May 2016 which looked at 29 sets of patients notes between February and April 2016 to determine compliance. This audit looked at the three steps of the checklist including sign in, time out and sign out, however did not audit compliance with steps one or five of the checklist (team brief and debrief). Results demonstrated 52% of WHO checklists had not been fully completed. Audit data measuring staff engagement and quality of the checklist process had not been completed and was not available.
- A previous audit complete in June 2015 audited the completion of the team brief step of the checklist and documented that in 30.5%(18) of theatre sessions there was no team brief step completed.
- Due to a number of never events, involving wrong lens implants, that had occurred previously in different areas of the trust, an intraocular lens (IOL) audit was completed. This audit assessed the IOL checking procedure when a member of theatre staff checks the patient details following the patient's arrival into theatres and a second check during 'time out' in line with trust guidelines. The audit demonstrated 100% compliance with the first check and noted improvement was required within the time out. During inspection, we

noticed that IOL check paper work was fully completed in six patients' notes and staff were able to describe to us the checking guidelines in detail and show us relevant paperwork, which required completing.

- Patients who required surgery who were assessed as being high risk (American Society of Anaesthesiology (ASA) grade III or greater) or patients who required post-operative overnight care had their surgery booked at the services at Moorfields Eye Centre at St. George's. This was to ensure appropriate care was available such as a high dependency unit and overnight patient facilities to ensure patient safety.
- There was a clear adult and paediatric patient transfer policy available on the intranet. The policy detailed the process to transfer patients if they required medical care or treatment overnight.
- There was a clear policy available, which outlined the admission criteria of the six bed observation ward. The policy was clear that patients who required monitoring for cardiac or respiratory problems or any patient who required intravenous medication was not suitable for the observation ward and would be transferred to a hospital with overnight facilities.

Nursing staffing

- Data provided prior to inspection demonstrated low vacancy rates within the surgical services. Both MacKellar ward and the observation ward were working at full staffing establishment. The largest vacancy of 5.5 WTE (whole time equivalent) rate was in theatres. Staff told us there were nurses due to start in post and that vacancies were managed through internal bank and agency staff.
- Staffing levels across the surgical services were sufficient to deliver safe patient care. Vacancies were managed with regular bank or agency staff. We were told that ward managers used an acuity tool once a year to measure and monitor staffing level in their areas.
- Planned and actual staffing levels for each day were displayed outside of each department and during inspection; the actual staffing numbers met the planned numbers for each ward area.
- Nursing staff we spoke with told us that staffing numbers were good and they were able to effectively care for patients. Staff described how they could be moved to different areas of the surgical services when required to cover staff sickness. Staff were generally positive about helping out in other areas and told us they received help in their areas when they were short. The matron of the services was seen helping out the day case wards at busy times and was available to help with patients on the observational ward when required.
- Sickness and absence rates amongst nursing staff from April 2015 to March 2016 were 4.14%, which was better than the national average of 4.44%.

Surgical staffing

- In January 2016, locum use within the surgical services was 1.6%. Data provided demonstrated a decrease in the use of locum staff since April 2015 when the use was 2.9% of all staffing. The surgical services directorate had the second lowest proportion of locum medical staff used compared to the other services within the hospital.
- Sickness and absence rates for medical staff were 0.72% which is better than the national average of 1.29%.
- Out of hours, there was an on call surgeon available. The medical staff within the emergency department would cover emergency work within the hospital for example for the patients on the observation ward.
- Out of hours, there was an on call anaesthetist available There was no on site cover and this was due to no medical patients staying in the hospital overnight. Patients staying on the observation ward were there for ophthalmic nursing care only. .
- We looked at anaesthetic rotas and job plans and found that the majority of lists were consultant led, with very few led by registrars or clinical fellows. The surgeon rota was similar, with the majority of lists consultant led

Major incident awareness and training

- The trust had a major incident plan in place dated June 2015 however: two members of nursing staff we spoke with were unaware of this and were unable to locate this on the intranet.
- The trust's emergency planning lead ran monthly training sessions, which focused on incident management. This training was available to senior managers and on-call site cover nursing staff. Incident

management training was also provided to some departments, such as pharmacy and theatre staff, however had not been provided to staff within the ward areas.

- Staff were aware of how to respond in the case of fire and told us there were yearly fire training and drills to ensure readiness if this was to occur.

Are surgery services effective?

Good

We rated the surgical services at City Road as good for effective. This was because:

- There were good patient outcomes across the specialties and the services performed well when compared to available national standards.
- Care was delivered in line with relevant national guidelines and we saw appropriate policies, procedures and clinical guidelines which referenced these.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Nurses and health care assistants felt well supported with good supervision and good training opportunities.
- Consent practices and records were actively monitored and reviewed to improve how people are involved in making decisions about their care and treatment.

However:

- Internal training was not always recorded or formalised and in theatres; there were no formalised competencies for nurses caring for children in theatre recovery and appraisal completion rates were low.

Evidence-based care and treatment

- Patient treatment guidelines, policies and procedures were in accordance with appropriate guidance from the National Institute of Health and Care Excellence (NICE), The Association of Anaesthetists of Great Britain and Ireland (AAGBI), The Royal College of Anaesthetists (RCoA), The Royal College of Surgeons (RCS), The Royal College of Ophthalmologists (RCOphth) and the Royal College of Nursing (RCN). We saw guidelines, policies and procedures reference these, with appropriate renewal dates.
- Due to the single speciality nature of the trust, many national audits were not relevant. The trust audits against standards and guidelines set by relevant national bodies such as the Royal College of Ophthalmologists, National Institute for Health and Care Excellence (NICE) and national service frameworks.
- A report published in August 2015 highlighted that for the period April 2014 – March 2015 195 clinical audits were registered however, only 69 had been completed. We were advised that this number was due to the recording system that was in place and that the trust was in the process of using a new system with better ways to record and share audit outcomes.
- Clinical staff were aware that there were still improvements required in the IT infrastructure, which would allow clinicians direct access to patient outcomes to compare results with national and trust outcome standards. Currently most audits completed required direct access to paper health records.
- Surgical services had not previously participated in the Royal College of Ophalmologists National Ophalmology database audit (RCOphth NOD) due to difficulties in transferring information from the current record system. The national audit database (NOD) collects data from services to show current and national performance and improve cataract care. At City Road, 1292 cataract operations took place in 2015/16. Participating in such audits allows ophthalmologists the opportunity to compare their surgical outcomes with those of anonymised peers. It also provides information to patients to help them choose their care based on available evidence. At the time of inspection we were told that the service had now started contributing to this audit and that future audit reports would reflect data from the City Road site.
- The pre- assessment service followed NICE, AAGBI and local guidelines to ensure appropriate pre-assessment of patients prior to operations.

- Nurses we spoke with were aware of some regular audits such as hand hygiene and environmental however many nurses we spoke with told us they were not involved in any of the audits and had not received training on how to conduct an audit.
- We saw published information in international journals demonstrating evidence of care and treatment performed within the surgical services. For example we saw a study conducted which looked at the broader benefits of squint surgery and research on secondary enucleations for melanoma.

Pain relief

- We were advised that most ophthalmic procedures caused little to no pain. However, nurses in recovery told us that pain would always be assessed and told us that if patients had pain this would be treated before discharge to the ward.
- Patient Group Directions (PGD) were available in theatres for pain relief medication such as paracetamol. This ensured timely administration of medicines by the nurses for patients who required this analgesia.
- Pain was measured via a verbal analogue score of 1-10 in adults and using the Wong baker faces pain score for paediatric patients.
- Nurses within pre-assessment discussed pain relief with patients and provided information on types of pain relief that patients could expect to receive as part of their procedure.
- A recent audit conducted by the anaesthetic team demonstrated an improvement in the management of pain in 2015 compared to an audit conducted in 2010. In the more recent audit 6% of patients experienced pain scores of more than four compared with 14% in 2010.

Nutrition and hydration

- Information was provided to patients during pre-assessment to explain when to stop eating/drinking depending on the time of their procedure; this information was also provided within patient leaflets. Morning patients were advised not to eat after 2am and not to drink after 6am. Afternoon patients were advised not to eat after 7am and not to drink after 11am. Patient who were having a local anaesthetic were advised to continue to eat and drink as normal. This was in line with the local policy which had been revised in January 2016
- Patients who were nil by mouth due to having a general anaesthetic, where possible, were given priority on the theatre lists to prevent long periods of time when they could not eat or drink.
- Patients who were having a local anaesthetic were provided with hot drinks during the morning or afternoon while they waited for their procedure.
- Housekeeping staff were available to provide drinks to patients on Mackellar ward only and drinks seemed to be more readily available to patients on MacKellar then on Sedgwick ward. On MacKellar ward, we saw regular drinks being offered to patients however, we did not see this available on Sedgwick ward where we also noticed the drinks machine was out of order.
- Hot sandwiches were available for day surgery patients after their procedure had been completed. We saw staff offering patients a range of different types of sandwiches.

Patient outcomes

- The anaesthetic department conducted a one week audit focusing on patient outcomes and satisfaction in theatres. The audit looked at the perioperative anaesthetic visit, VTE assessment and prophylaxis, pain scores in recovery and patient satisfaction. Results from the audit demonstrated improvements from the previous 2010 audits and we noted that action plans were put in place.
- Audit data provided on posterior capsule rupture (PCR) demonstrated a rate of 1% (50 cases) from September to November 2015. This is an improvement on the previous year's rate of 1.3% and is better than the rate reported by the Royal College of Ophthalmologists National Ophthalmology Database audit was 1.8%
- Best corrected visual acuity (BCVA) was also measured and results from September – November 2015 demonstrated that 91.2% of patients had a post surgery BCVA of 6/12 or better. This is better than the national ophthalmology database audit result of 89% of patients who had a BCVA of 6/12 or better,

Surgery

- Data provided by the surgical services demonstrated that 88.4% of patients had a +/- 1 dioptre from intended final refraction post surgery. College cataract guidelines (2010) recommend a >85% +/-1 dioptre.
- Data provided demonstrated the success of primary retinal detachment surgery against the national standard. The trust reported a success rate of 88%, which is better than the national standard of 75% or more.
- The complication rate of strabismus surgery (surgery to correct the misalignment of the eyes) from January to December 2015 was recorded as 0.23% which is better than the national standard of <2.2%.
- The retinal service audited complications and redo surgery for all ptosis, ectropian and entropion (lid malpositions) surgery performed between September 2014 to 31st December 2014 to ensure compliance with trust standards. Results demonstrated there was no significant difference in complication and success rates between the 2013 and 2014 audit and that results met the standards set by the British Oculoplastic Surgery Society (BOPSS). However, no audit data was available for 2015.
- Audit data provided demonstrated services were meeting the national standard required to urgently treat patients with advanced diabetic retinopathy.
- Glaucoma 'tube' surgery (implanting a valve) outcome audits demonstrated 82% of patients had a 20% reduction in pressure at one year. This is better than the national standard of 80%. Trabeculectomy core outcome data which looks at the success of glaucoma surgery demonstrates the service is comparable with other national services.

Competent staff

- Staff competency was regularly monitored through clinical supervision and the staff appraisal process. There were education link nurses available for theatres and the surgical wards. Education link nurses worked to ensure staff were assessed and competent in their roles.
- Staff had access to ophthalmic education training days, which took place on a Saturday. Staff were able to claim this time back as time off in lieu (TOIL) or paid overtime. Topics included biometry, emergency eye care and ophthalmic pharmacology.
- Health care assistants had access to a training journey which compromised the care certificate, technician course, assistant practitioner course and then registered nurse training in which secondment opportunities were available. During the inspection, we spoke with health care assistants who had access to this training and who were at different stages of this learning journey.
- In theatres we saw competency documents in use to assess nurses' competence to count all swabs, suture needles, instruments and other accounted for items prior to, and on completion of surgical procedures.
- Senior staff were aware of the implementation date for nursing staff revalidation and were preparing nurses for this. There was a nurse leading on revalidation within the trust who was engaging with staff members nearing their revalidation date. We saw posters advertising information on staff noticeboards.
- Recovery staff in theatres that cared for children told us they had ongoing training and development before being able to work with children and young people. However, nurses told us there was no formal procedure in place to assess their skills and a senior member of staff told us that this was under development.
- Records showed 44% of staff within the surgical services directorate had an up to date appraisal against the trust target of 80%. This meant that 225 staff members did not have an up to date appraisal.

Multidisciplinary working

- The surgical services had external agreements with other hospitals to transfer patients when required for overnight care or when complications arose during or after surgery. For example, acute medical patients would be transferred by ambulance service to the Royal London Hospital.
- All wards had at least one dedicated pharmacist available between 9am and 6pm daily Monday to Friday, situated within a Day-Care Unit pharmacy (and separate private pharmacy for the Frances Cumberlege wing).They were responsible for screening drug charts, medicines reconciliation, ordering drugs from the main pharmacy, ordering to take out (TTO) medicines for patients and counselling certain patients on specific medicines usage.

- We observed porters, healthcare assistants, nurses and doctors of different levels communicating well with each other to ensure safe and effective care.
- We saw evidence of weekly MDT meetings that took place where patient care and treatment was planned and discussed in detail. We saw that meetings were split by different eye conditions and we saw minutes of meetings for ocular oncology, melanoma and non melanoma.

Seven-day services

- The surgery services provided elective care and treatment Monday to Saturday and a seven-day emergency service.
- Overnight care was provided for patients requiring ophthalmic nursing care only. There was no medical care provision for patients overnight and therefore patients who required this would be transferred to other hospitals.
- Day case surgery took place Monday to Friday with extra patient lists on a Saturday during busy times. Surgery for private patients took place mostly in the evenings after 6pm.
- The vitreo-retinal emergency (VRE) clinic was open from 08.30 to 1pm Monday to Friday and from 07.30 – 11am at weekends. There was on-call provision provided each day until 5pm

Access to information

- An information hub was available within the hospital where patients could access written information about eye conditions and other public health information. We saw engagement with other services such as diabetes UK, The Macular Society and Blood Pressure UK.
- Leaflets about different types of eye conditions and treatments were available throughout the hospital including the wards and hospital corridors. We were told that these were available in other languages on request.
- Nurses told us that policies were available on the intranet and demonstrated how to access these. Computers were available at the nurses' station and in offices.
- Risk assessments, care plans and test results were completed at appropriate times during the patients' care and treatment and kept within the patients' main notes folder. These were mostly available when required however, some notes were not always tracked appropriately, resulting in patients needing temporary notes. We were advised that one patient procedure had been cancelled over the last year as the result of patient's information not being available when required.
- Staff had access to a system which provided live tracking data throughout the patient's surgical pathway. Nurses were able to view amended list orders and when a patients surgical procedure had started and finished. Staff told us this system was useful, easy to use and had improved the quality and accuracy of information they could give to patients about waiting times.
- General Practitioner (GP) discharge letters were given to patients before they were discharged from the ward. We saw evidence of letters being prepared ready to give to patients before they left the ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at 10 patient consent forms in detail. All consent forms were signed and dated by both the patient and the clinician. However, we found that the top copy had not been given to the patient.
- Regular audits were completed to ensure compliance with obtaining appropriate valid patient consent in line with the trust's consent policy.
- Staff told us about Mental Capacity Act 2005 (MCA) prompts they had been provided to assess whether patients had the mental capacity to give informed consent. Staff were able to discuss in detail how to assess capacity and when a best interest meeting would be required. Staff were encouraged to speak up if they had concerns about any of the patients in their care.
- We saw Deprivation of Liberty Safeguard (DoLS) information displayed on staff boards. A flow chart had been developed to aid staff decisions of whether a DOLs application was appropriate.
- The DoLS policy and process was available for staff to access on the intranet including single page summary sheets.

Surgery

- Staff on the wards had a clear understanding of when a DoLS application was necessary. They were able to demonstrate scenarios where an application was deemed appropriate.
- Mental Capacity Act (MCA) training was mandatory within the trust. Data provided demonstrated 32% of surgical services staff had completed MCA training against the trust target, which was set at only 30%.

Are surgery services caring?

Good

We rated surgical services at City Road as good for caring. This was because:

- Feedback from people who use the service and those who are close to them was continually positive about the way staff treated them. Patients thought the care they receive exceeds their expectations.
- Friends and Family Test results were consistently good across surgical services.
- Staff were seen to spend time talking to patients, or those close to them, to ensure they received the information in a way they could understand and were given time to ask questions.

However

- Privacy and dignity was not always prioritised and we observed times when staff could have done more to promote this.

Compassionate care

- In January 2016 the surgical services directorate had a Friends and Family Test (FFT) response rate of 40.7% which is above the national average of 35.5%. Of these, 99.5% of patients said they would recommend the services. The February 2016 FFT results demonstrated that 100% of patients would recommend the services on Cumberlege ward, the observation ward and in the Vitreoretinal emergency clinic.
- In June 2015, a survey to capture the views and experiences of patients in theatre found that 95% of patients felt supported throughout their care.
- The areas we visited were compliant with the same sex accommodation guidelines. The trust reported no same sex care breach throughout 2014-2015.
- Patient privacy and dignity was maintained when possible by the use of curtains around bed spaces. However, in the day surgery area we saw staff talking to patients about their care while sitting in the main waiting room, which could be overheard by other patients.
- In the recovery area, screens were available to use around patients. However, we observed a patient recovering from a general anaesthetic when another patient walked past, where these screens were not used therefore compromising the privacy of the patient.
- Patients we spoke with were positive about the care they had received and told us nurses and doctors were kind and compassionate. Patients told us they had been put at ease by staff with one patient commenting that the “staff were fabulous and took all my fears away”
- Staff we observed during pre-assessment appointments and during the checking in process on the ward were kind and respectful towards patients, taking their time to ensure they answered questions and concerns in full.

Understanding and involvement of patients and those close to them

- All patients we spoke with said they were aware of their surgical procedure and that it had been explained to them thoroughly and clearly. Patients told us they had been given time to ask questions to ensure understanding.
- Patients told us that staff kept them informed about the waiting times and how many patients were ahead of them on the theatre schedule.
- Patients we spoke with commented that they had been given useful information such as leaflets prior to surgery to ensure they felt educated, supported and prepared for surgical procedures.
- Patient told us they could book their follow up appointments during their preassessment clinic visit. This ensured patients could identify times to suit them and to fit around their schedules.
- “Moorfields Direct”, a phone line staffed by ophthalmic nurses, was available Monday to Saturday and provided information, support and reassurance to patients.

Emotional support

- Counselling, emotional and psychological support, as well as practical advice and information on services outside the hospital was provided by the integrated patient support services. The team consisted of nurse

counsellors, eye clinic liaison officers (ECLOs) and the certificate of visual impairment team. The team provided help and advice for patients who had to deal with news about sight loss.
- All of the nursing staff we spoke with on the surgery wards demonstrated a very compassionate approach and we observed nurses carefully listening to patients and providing reassurance.

Are surgery services responsive?

Good

We rated surgical services as good for responsive. This was because:

- Staff, teams and services were committed to working collaboratively and found innovative and efficient ways to deliver joined up care to patients within the services, which aimed to reduce wait times and improve utilisation.
- The surgical services had implemented a number of improvements throughout the patient pathway, including a 'one stop' nurse led assessment clinic which including investigations if needed and a live patient tracking system.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that recognised and promoted those needs.
- Patients were given the flexibility to access services in a way and at a time that suited them.

However

- Performance targets demonstrated a high number of both clinical and non clinical cancelled operations.

Service planning and delivery to meet the needs of local people

- Information and advice was available via Moorfields Direct telephone helpline, which was staffed by ophthalmic trained nurses. The helpline was available Monday to Friday 09.00 – 9pm and on a Saturday from 08.30 - 5pm. Patients told us this was a useful service as many patients travelled long distances and told us it was convenient that they could access advice via telephone.
- A hostel service was located on MacKeller ward and was available to patients who had to travel long distances for their treatment. The hostel service provided a place for patients to stay the night before their procedure. Suitability for the hostel style accommodation was assessed at pre assessment and patients were advised that there was no medical cover over night.
- Volunteers were available at the entrance to the hospital to meet patients who required assistance to find the wards and departments. A green line directed patients from the tube station to the hospital and a blue line directed patients to the main lift area.
- During inspection, we noted that some areas were difficult to access. For example, the signs for MacKeller ward were confused with an exit sign above and the directions to theatre nine were unclear and difficult to follow.
- There were drop in clinics available for patients to allow their pre assessment to take place immediately after their outpatient consultation.

Meeting people's individual needs

- The surgery service proactively considered and responded to specific individual needs, including patients with complex needs and cultural and religious requirements. Staff we spoke with were able to tell us in detail and give examples of how they met the needs of different patients
- There was a multifaith quiet room available on the first floor, this was open for patients and their relatives to utilise if they required a quite space.
- Pathways were available on each of the wards for patients with dementia or learning disabilities. We saw examples of the day care pathway and the theatre pathway. Staff spoke with us about how they would adapt the service including the use of side rooms, ensuring patients were early on the theatre list, allowing relatives and carers to accompany patients into theatres and facilitating visits to the service before the day of their procedure.
- A welcome pack had been developed specifically for patients with a learning disability. The pack demonstrated the patient's journey through pictures and included information about what equipment, staff and post-operative eye dressings might look like.
- Staff told us they had yearly training in caring for patients with a learning disability and dementia awareness. They told us they needed to pass an assessment before this training was completed.

- Patients with a disability, a visual or hearing impairment, or elderly patients who required additional help were identified with a 'helping hand' sticker on the front of healthcare records. These stickers informed staff that the patient might need extra help. However, these stickers did not identify what type of help or support the patient might need.
- A flagging system was available on the appointment booking system. This meant staff could identify patients on the following days list and make preparations, if extra help or adjustments were needed.
- “This is me” booklets were available for patients with dementia. Staff told us these booklets helped to inform them how best to communicate with the patient about their likes and dislikes.
- Each area of the hospital we visited had a learning disability and a dementia link nurse who could advise staff and support the care of patients.
- There was a range of information available to patients about different aspects of their care. However, this information was only available in English and not immediately available in other languages. On discussing this with staff, we were told that these leaflets were available in different languages and available in easy read format on request, however there was no information that prompted patients to ask for these leaflets.

Access and flow

- There had been significant projects on going to improve the patient flow through the surgical services and this was evident in many areas of the service we visited.
- The surgical pre assessment clinic was a nurse led service with both a booked appointment based service and walk in appointments available. Patients were able to see the nurse and have the appropriate tests performed when necessary including blood tests, infection screening and an ECG. Staff aimed for patient appointments to take between one to two hours and the lead nurse monitored arrival and assessments times.
- The patient’s surgical pathway was planned during pre-assessment. This ensured patients could consider whether dates for surgery and post surgery appointments were appropriate and new dates could be considered according to patient preference to ensure flexibility.
- Telephone clinic appointments had been implemented to reduce patient waiting times and were available for patients with no general health concerns. Patients appropriate for telephone assessment had bloods and other tests performed in clinic and then had a nurse led telephone appointment at an appropriate time for the patient.
- The service had adapted its policies to extend the validity of pre assessment screening in patients who were returning for further operations. For example, pre assessment reports were valid for six months for second eye cataract patients and four months for other patients if there had been no change in the medical history of the patient.
- Anaesthetists were available during the afternoon to assess patients when needed to prevent patients having to reattend for a further appointment. In the mornings, the nurses had access to an on call anaesthetist if patients required anaesthetic input.
- There was a vitreo-retinal emergency (VRE) clinic open Monday to Friday 08.30 - 1pm and 07.30 – 11.00am at weekends. Outside of these hours there was an on-call VR doctor available for advice. The emergency department doctors, GP or optician could refer patients into this service. Patients arriving at the clinic were assessed and prioritised for treatment according to the severity of the condition. Treatments were carried out in the afternoon including laser and emergency surgery. Depending on the severity, patients either would be treated in the afternoon of their attendance or would be asked to come back for treatment on a different day. Due to the highly specialised service, the clinic accepted referrals from all over the country.
- Patients arrived on the morning or afternoon of their planned surgery day. Most morning patients arrived at 07.30 and afternoon patients at 12.00. The consultant saw all patients prior to their operation. Patients were prioritised through consideration of health and social needs. Patients and staff recognised that patients at the end of the session lists could be waiting for long periods. Work was ongoing to consider how improvements could be made.
- Some afternoon patients were required to attend in the morning to have repeat tests performed before surgery.

Staff were aware this meant a long wait for these patients but prevented them attending on a separate day. One patient commented that this was preferable, as they had travelled a long distance for this procedure.

- Patients were kept informed of the list order and how many patients were in front of them. A live system had recently been implemented to ensure live tracking of patients, this ensured the nurses on the ward could give accurate estimations of theatre times and were aware of any disruption to patient care or treatment.
- Patient flow through theatres had also improved through staff reviews of the patient' journey. Patients who had procedures under local anaesthetic without sedation would go straight back from theatre to the day surgery ward for discharge. It was recognised by staff that sending these patients to the recovery area caused delays for other patients needing a space in recovery and delayed the patients' discharge.
- Cancellation rates from April 2015 to January 2016 were not meeting trust targets of less than 6%. Data provided demonstrated 9% of operations were cancelled due to theatre cancellations. During inspection, we were advised that theatre refurbishment had taken place between April to November 2015 and this had caused some disruptions. We were advised that theatre cancellation rates were improving since this work had been completed however, data provided demonstrated that theatre cancellations remained above 10% from December 2015 to February 2016 and were 9% in March 2016. The highest number of theatre cancellation occurred in January 2016, when there were 244 theatre cancellations out of 1,965 operations.
- Cancellation rates were discussed every other week in a multidisciplinary meeting between the surgical consultant, anaesthetic consultant, theatre manager and the surgical service matron.
- Data provided demonstrated the largest cancellation rate was within the adenexal service. We were advised that this was due to the nature of the service, as symptoms can resolve quickly and therefore an operation is no longer required.
- We were advised that clinical cancellation rates were improving. However, data demonstrated performance was at 4.2%, which is worse than the trust target of less than 2.5%. We were advised that clinical cancellations could be challenging in some patient groups, such as oncology patients, as the patient's clinical condition could change rapidly from pre assessment.
- Data provided demonstrated that all patients who had their operations cancelled for non medical reasons by the surgical services were treated within 28 days in line with national performance standards.
- Theatre utilisation information was available within the theatre department and staff were able to compare this to other services elsewhere in the trust. The trust target for theatre utilisation was 90% and information demonstrated that the City Road site was constantly meeting this target. Theatre utilisation had been above 90% in February, March and April 2016. In February 2016 City Road theatres had the highest theatre utilisation results compared to other locations within the trust
- The surgical services performance for Referral to Treatment times (RTT) had steadily improved from January 2016 – March 2016. Referral to treatment performance for the Surgical Directorate was 95.2% of patients at March month end exceeding the 92% national target.
- Data provided demonstrated surgical services were meeting relevant cancer waiting time targets. Performance summaries from January to March 2016 demonstrated 100% compliance for the 31 day wait from diagnosis to treatment and 100% compliance for the 62 day wait from urgent GP referral to first definitive treatment.

Learning from complaints and concerns

- Between April 2015 and March 2016 the surgery services directorate received 39 complaints, of which 21 were classified as moderate, 11 as low and seven unknown. The surgical services directorate aimed to respond to over 90% of all complaints within 25 days. Data provided demonstrated that 84.6% of these had been responded to within the trust target of 25 days.
- Senior staff told us that they would try to deal with complaints directly to prevent them escalating. Staff were aware that the matron of the service was available to help with this and could be accessed via a bleep if they had patient concerns that could not be resolved by them.
- Information about how to make complaints was available on the wards and throughout the hospital corridors. Senior staff told us that complaints would be passed to the areas concerned to ensure adequate responses and monitoring of patient care.

- Posters and leaflets explaining how to make a complaint were widely available throughout the department.
- There was evidence of learning from complaints. Each ward had a quality and safety board where reported complaints and concerns were displayed and actions taken were communicated.
- Staff we spoke with told us the largest complaint topic was regarding waiting times on the day case wards. Some of the surgical specialities were addressing this issue through staggering patient's arrivals however, other services were still discussing how this could be improved.

Are surgery services well-led?

Good

We rated the surgical services as good for well-led. This was because:

- There were a clear set of vision and values within the surgical services that were driven by quality care and safety. Staff were clear of their involvement in delivering these objectives.
- We found a cohesive and supportive leadership team who functioned effectively, with well established members of staff. Staff were complimentary about the support they received from their seniors and commented that they were visible and approachable. Structures, processes and systems were in place to ensure information sharing across the services was effective.
- There was a clear proactive approach to seeking out and embedding new and more sustainable models of care from all staff levels within the services.
- There were high levels of staff satisfaction across all equality groups. Staff were proud of the organisation as a place to work and spoke highly of the culture and opportunities.

Vision and strategy for this service

- The trust describes it's vision to be the "leading international centre in the care and treatment of eye disorders, driven by excellence in research and education". The trust had a clear set of values to strive to give people the best possible visual health, effectively and efficiently through professional teamwork and partnerships while putting patients at the centre.
- There was a clear vision and set of objectives, which were well defined within the surgical directorate, and the objectives were aligned with the trust's vision and 10 year strategy. Senior staff were able to discuss in detail these objectives and what had so far contributed to achieving these. Staff told us there was still room for improvement and were aware of challenges including the environment and the IT infrastructure. We saw objectives displayed in staff areas and although junior staff were unable to discuss these in detail they were aware of the objectives relevant to their role and working area for example improving patient flow, ensuring safety and minimising patient waiting time.
- Trust objectives were displayed in staff areas and on handouts, although staff had little understanding of how these related to their practice and were unable to give examples of how they were meeting these in practice.
- Staff within the surgical directorate were keen to discuss 'The Moorfields Way' values to be caring, organised, excellent and inclusive. Staff told us that their appraisals focused around these values. We asked staff how these values contributed to their day to day work and staff were able to demonstrate these values in action.

Governance, risk management and quality measurement

- The risk register for the surgical services was updated regularly and was rated by multiplying the consequence by the likelihood. We noted some risks had been on the register since 2013 however, these were updated regularly with action points. We noted that all risks above a level of 12 had been escalated to the corporate risk register in line with trust policy.
- Clinical governance structures were in place across the surgery services and senior staff we spoke with said they were effective. Monthly meetings took place for each of the surgical specialties, which fed directly into the surgical services directorate meeting. We spoke with ward managers, the matron and the theatre manager who were able to demonstrate good awareness of the governance arrangements within the directorate.
- There was a strong focus on information sharing throughout the surgical services. Staff told us information from department meetings were cascaded

up to the directorate meetings. Action points and outcomes from the directorate meetings were cascaded back to the ward staff during weekly meetings or the monthly department meeting.

- Senior staff were able to describe the actions taken to monitor patient safety and risk. This included incident reporting, completing regular audits, sharing learning and feeding back to other staff. However, junior staff including band 5 and 6 nurses were not aware of quality measurement and told us they were not involved in audits. Some nurses were aware of hand hygiene audits, which took place within their departments however, they were not able to discuss any involvement in improvement audits.
- Department meetings took place monthly and we saw topics to discuss lists in staff areas where staff could suggest items for the agenda. Managers told us that improvement ideas could be discussed at these meetings along with incident themes, current risks and learning. We were told that these meetings were not minuted however followed a similar format as the directorate meetings as this gave managers and opportunity to feed back the discussions with the ward staff.
- Monthly surgical service meetings took place and minutes reviewed demonstrated good attendance from managers, matron, senior nurses and admin staff. We saw a range of topics discussed including cancelled operations, quality metrics, finance and complaints.
- Detailed monthly performance reports were produced to identify trends in performance. Performance reports including information on efficiency, safety and compliance.

Leadership of service

- The clinical director, general manager, deputy general manager and nurse manager led the surgical services at city road. The service was then split into seven separate divisions that were led by a service director and service manager.
- Staff we spoke with were clear about who their service leads were and commented that they were visible and accessible. Posters were available throughout wards and departments, which demonstrated the leadership structure of the service.
- The leadership team were keen to drive continuous improvement within their areas of the directorate. Staff were encouraged to deliver change, which improved patient experience and the patient journey. Staff were encouraged to share ideas through suggestion boxes and monthly department meetings, which were then fed into the surgical services monthly meetings.
- Junior staff commented that the matron and theatre manager had an 'open door policy' and commented that they were supportive and visible during busy periods.

Culture within the service

- There were high levels of staff satisfaction across all staff we spoke with. We spoke with over 30 staff members of different levels and equality groups. All staff we spoke with told us they had opportunities to develop and felt included in decisions that were made.
- Staff were proud of the organisation as a place to work and spoke highly of the supportive culture. Staff we spoke with were happy with their working environment and when asked what staff like most or feel most proud of, a large number of staff commented that it was their team.
- Health care assistants (HCAs) told us there were opportunities to progress through the learning pathway. We spoke with one HCA who informed us he felt supported throughout his career from a HCA to his nurse training and was proud that he had been given the opportunity to make a difference to patients through his learning, development and extended role.
- Staff progression was evident within different areas of the surgical services. Nurses had access to external courses and were encouraged to find and apply for learning opportunities which interested them. We spoke with one nurse in the recovery department who had a keen interest in caring for patients with diabetes. They had become the link nurse in their area due to external courses, conferences and study days attended.
- Staff told us they were encouraged to raise concerns and had a clear understanding of who to raise these concerns with. Nurse managers told us they had an open door policy and staff echoed this telling us they felt comfortable addressing concerns or improvement ideas.
- Senior members of staff told us a lot of work had been committed to breaking down the hierarchy and improving the culture in theatres to reduce never events and enable all staff to ensure patient safety. In theatre, we spoke with senior operating department

practitioners, nurses and support staff who all commented that they felt able to challenge practice and discussed a happier and healthier working environment.

Public engagement

- Patient experience committee meetings took place every other month, where patients and relatives were able to attend to give feedback about the services to the matrons and other senior member of staff.
- Staff informed us about audits completed to help improve the wording of patients letters. As part of this audit 50 patients were handed questionnaires to complete about their views and satisfaction of the letters. Patient representatives were also invited to attend audit and effectiveness meetings This provided an opportunity for patients to participate in decisions affecting their care.

Staff engagement

- We saw staff noticeboards available throughout the surgical departments providing staff with information about departmental and trust wide changes, including available training and development opportunities.
- A recent theatre working group had been formed which involved staff from both the theatres and the day surgery wards. Staff met to discuss improvements in the patients' journey to encourage transparency, improve understanding and to work together to improve the patient experience.
- There was a magazine called 'In focus' circulated to staff, patients and visitors. The magazine celebrated improvements in care, published staff survey results including actions and shared patient stories.

Innovation, improvement and sustainability

- Moorfields eye hospital works in collaboration with the UCL Institute of Ophthalmology, forming a large research partnership. The surgical services demonstrated there were 20 ongoing research projects which they were involved in to improve patient care.
- Due to the sharp increase in the demand for intravitreal therapy the services had recently enhanced the nurse practitioners role to enable intravitreal injections (administration of drugs inside the eye). This is supported by The Royal College of Ophthalmologists and we saw up to date standard operating procedures and guidelines in place.

Services for children and young people

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

Information about the service

Moorfields Eye Hospital NHS Foundation Trust provides care and treatment for children and young people with ophthalmic conditions within the Richard Desmond Children's Eye Centre (RDCEC) at City Road. This is a purpose built dedicated children's facility. Care is provided within the RDCEC for children and young people up to the age of 16 years.

Children's and young people's services comprises:

- An Accident and emergency (A&E) department which is open between 9am and 4pm Monday to Friday. Outside these hours children attend the accident and emergency department (A&E) in the main hospital.
- A 12 bedded day surgery ward. There is no inpatient care within the RDCEC for children and young people who require an overnight stay and these children are transferred to other hospitals.
- Two paediatric surgical theatres and a children's recovery area.
- An outpatients facility

The RDCEC provides a service for the local population and also accepts secondary paediatric ophthalmic referrals and tertiary referrals for all ophthalmic specialties. For the four months from September 2015 to December 2015 there were 297 admissions to the day surgery ward, 1,503 A&E attendances and 8,830 outpatient attendances in the RDECC

We visited the A&E department, day surgery ward and the outpatient's clinics on two floors of the RDCEC.

During the inspection we talked with four children and young people and 13 parents/relatives.

We talked with 28 staff, including, ophthalmology consultants, anaesthetists, registered nurses, a healthcare assistant, an optometrist, an orthoptist, an operating department practitioner, a play specialist, administrative staff, student nurses, a paediatric sister, matron, and the senior leadership teams. We looked at five care records and observed care provided. We also reviewed documentation provided by the trust including performance information.

Services for children and young people

Summary of findings

Overall we rated the services for children and young people as good.

- Systems and processes were in place to promote the delivery of safe care. Incidents were appropriately reported and investigated and the lessons learned were communicated to staff. Cleanliness was good and infection prevention and control practices were regularly monitored. Staff had received training in relation to safeguarding children from abuse and they were clear about their responsibilities.
- The service contributed to the development of national standards and clinical guidelines for ophthalmology and implemented this guidance in practice. The outcomes of treatment for patients were monitored and compared with other providers to ensure continuous improvement. Children and young people benefited from a multi-disciplinary approach to care within a purpose built setting.
- Parents, children and young people were overwhelmingly positive about the kindness and compassion of staff and their cheerful and calm approach. Their involvement in their care was facilitated by the clear explanations and high quality written information provided. The importance of emotional support was also recognised and the family liaison team provided additional emotional support.
- The individual needs of children and young people were accommodated and there were processes in place to ensure the smooth transfer to adult services if they required on going treatment when they reached 16 years of age. Patient pathways had been mapped and steps taken to improve the flow of patients through the services to reduce waiting times and avoid repeated attendances as much as possible.
- We found good clinical leadership and staff felt supported. A clinical governance framework was in place but there were no clear quality targets or priorities for the service. A comprehensive programme of research was being undertaken, new services were being developed and the expertise within the service was reflected by the published research in national journals.

Services for children and young people

Are services for children and young people safe?

Good

We found the safety of services for children and young people was good because:

- Incidents were appropriately reported and investigated and lessons learned were communicated to staff
- Patient risks were appropriately identified. This included effective use of a pre-operative assessment, paediatric early warning score and the safer surgery checklist.
- The environment and equipment within the operating theatres, recovery, ward areas and the outpatients department were visibly clean and hygiene checks were taking place.
- Staff were clear about their responsibilities for safeguarding children and young people.

However, we also found:.

- There was no information to demonstrate the consistent use of the WHO safer surgery checklist in children's and young people's services and a general surgical audit indicated poor compliance.

Incidents

- Between October 2015 and January 2016, 98 incidents were reported for the service. Senior staff were aware of the themes from the incidents and issues had been escalated through the clinical governance framework where necessary, for example, problems with the availability of health records following changes to the library system.
- Incidents were reported through an electronic system and staff were confident in the use of the system. They told us they received feedback by email or in person following submission of an incident and following the investigation.
- A consultant we spoke with said monthly incident reports were sent by email to all medical staff.
- Staff were able to give examples of feedback they had received following incidents. They told us they were encouraged to report incidents and the emphasis was on ensuring learning occurred to prevent recurrence wherever possible.
- Incidents and actions taken as a result were discussed within the paediatric services meetings and at the clinical governance half days.
- Staff were aware of their responsibilities under the duty of candour, which ensures patients and/or their relatives are informed when they are affected by something which went wrong and given an apology.
- A member of staff we talked with gave an example of an incident which had occurred when the incorrect amount of a medicine had been administered. Staff told us the anaesthetist had come to the ward and informed the child's parents and apologised to them.

Cleanliness, infection control and hygiene

- There were no cases of post-operative endophthalmitis or health care associated adenoviral conjunctivitis between April 2015 and March 2016.
- Trust data indicated monthly hand hygiene audits were completed and showed compliance above the trust target of 95% in all months between April 2015 and March 2016 apart from November 2015 when compliance was 88%.
- Hand gel was available at the entrance to all clinical areas. Staff were bare below the elbows and we observed them cleansing their hands prior to patient contact. Patients and parents also told us staff cleansed their hands before providing care.
- Cleaning schedules were in place for all areas within the RDCEC with clear instructions on the frequency of cleaning and the method and equipment to be used.
- Monthly cleanliness audits were undertaken and trust data indicated scores of above 93% were obtained each month between April and December 2015. The trust target for cleanliness was 95% and this target was achieved in six of the nine months. When we checked the cleanliness of the environment and equipment, all areas appeared visibly clean.
- A toy cleaning programme was in place, and we found the rota had been completed consistently.
- Personal protective clothing and equipment was available in every bay and side room within the ward and within clinical areas in the outpatients department and accident and emergency department.
- Infection prevention and control (IPC) policies and procedures were current and accessible for staff.
- IPC information and audit results were displayed within the day case ward.

Services for children and young people

Environment and equipment

- The RDCEC had been designed with the care of children as its focus and was light, bright and child friendly and met the requirements of the Building Regulations 2000. There were low glass barriers around the atriums on each floor with a hand rail approximately a metre above the floor which meant they were compliant with part K section 2 (Building Regulations 2000): protection from falling, collision and impact. The glass barriers were well within the minimum height requirement but had been identified as a potential risk and recorded on the risk register (patients may attempt to jump over them or throw objects over them). Divisional leaders said the controls in place were felt to be sufficient to manage the risk. Controls included providing information to parents and ensuring staff were aware of their responsibility to monitor the waiting areas.
- There were two allocated operating theatres for children and young people and a dedicated recovery area. The two theatres were used for adult patients when not in use for children however, this arrangement enabled children and young people to be cared for without contact with adult patients in a safe and appropriate environment
- There was secure entry to the day case ward and the areas beyond reception in the A&E department, which were accessible only with an electronic card.
- Resuscitation equipment was available in the ward and the children's recovery area. Daily and weekly checks had been completed in line with requirements.
- The recovery area was well equipped with clinical decision making equipment and monitors.
- Portable appliance testing (PAT) had been carried out and the equipment we checked indicated it was in date. Trust records indicated there was a programme of regular maintenance and PAT testing of equipment.
- Staff reported that there was sufficient equipment to meet patients' needs and the equipment service was able to provide replacements when necessary. They told us that if new equipment was needed, authorisation was normally obtained to order what was required.

Medicines

- Arrangements for the supply of medicines were good. We found no evidence of out of stock medicines during the inspection and there were effective arrangements to reconcile medicines that had been ordered and advice out of hours by the on-call pharmacist. Staff we spoke with said they had no issues obtaining medicines from the pharmacy when needed.
- In the clinical areas, medicines were stored securely and in line with requirements. The temperature of the room used to store medicines on the day case ward had exceeded the recommended temperature on an occasion within the last three months. Pharmacy were notified and checks with the manufacturers had been carried out to ensure medicines stored in the room would not have been affected
- Checks we carried out on the controlled medicines indicated that the required documentation was in place and had been completed consistently.
- The percentage of tablets to take (TTOs) home reaching the children's wards within the trust's target of 20 minutes had been maintained, demonstrating that discharge medicines were received in a timely manner by patients.
- Patient outcomes from medicines were monitored and assessed via several audits conducted on the children's wards. These included audits of controlled drugs, Patient Group Directives (PGDs: a written instruction for the supply and administration of a specified medicine), antibiotics (such as moxifloxacin), medicines reconciliation, interventions and safe storage of medicines.
- The pharmacy in the RDCEC was open between 09:00 – 17:30 Mondays to Fridays, staffed by one pharmacist and one pharmacist technician. Out of hours, the department had access to an on-call pharmacist out of hours who could be contacted for advice and assistance with medicines supply issues.
- There was an open hatch to hand in prescriptions and collect medicines (there is a separate door which then leads into the main dispensary). As this pharmacy was usually staffed by one member, the female pharmacist we spoke with identified a risk to her security as it was possible for someone to reach in and grab her (given the open access of the pharmacy in the reception area on the ground floor). However, this had been risk assessed and the trust was currently in the process of procuring a shutter to close the hatch when not in use (or when the pharmacist was not there).

Records

- Health records we reviewed were complete, legible, and up to date. They had been signed and timed and the designation of the signatory was printed underneath the signatures.
- Records were stored securely to prevent access by unauthorised persons.
- A day case care pathway was in place which included a pre-operative assessment, pre-operative checklist, anaesthetic and operation record, recovery notes and a discharge checklist. However, there was no specific information on the care required on the ward prior to discharge.
- Staff we talked with were conversant with the post-operative nursing care required but it was not possible to identify this from the pathway documentation. This meant that the requirements may not have been clear to temporary staff.
- Consent documentation, safety checklists, vital sign observations and paediatric early warning scores (PEWS) scores were available in the care records.
- Discharge letters to GPs were written prior to patients being moved back to the ward and provided clear information on the admission and procedure carried out.

Safeguarding

- Overall, 92% of staff had attended children's safeguarding training at level 1. Of those staff who required children's safeguarding training at level 2 and 3, 97% and 91% respectively had received training against a target of 80%. 95% of medical staff and 100% of locum medical staff had completed level 2 training. 94% of registered nurses and 100% allied health professionals had also completed level 2 training.
- A safeguarding children and child protection policy and procedure was available and staff were aware of how to access it.
- Staff we spoke with in all areas of the RDCEC were able to tell us about child protection, how to report issues and about safeguarding procedures.
- They told us they felt well trained and well supported in relation to child protection. Staff were aware of who was the named nurse for child protection and were confident of their support in case of a concern.
- We reviewed incidents reported in relation to safeguarding and saw that staff were alert to possible signs of abuse and raised their concerns appropriately. There was very prominent information about safeguarding and telephone contact numbers on display on the walls of the recovery area.
- The trust had developed a safeguarding children intranet page to provide information for staff with links to the policies and procedures.

Mandatory training

- Staff told us they had access to mandatory training and they were reminded when their training was due.
- Data provided by the trust indicated that overall compliance with mandatory training was above the trust target for staff working in children's and young people's services in all topics except training in moving and handling level 1 (object handling) in which 52% of staff had completed the training as compared with the trust target of 80%.
- Staff had received training in adult and paediatric life support. 83% of staff had completed paediatric basic life support and 81% had completed paediatric immediate life support (PILS) exceeding the trust target of 80%.

Assessing and responding to patient risk

- Most children and young people undergoing surgery were otherwise physically well and there was no overnight service for children. Any patients who would require an overnight stay were admitted to other hospitals such as the Royal London Hospital or Great Ormond Street Hospital for their surgery.
- When a child or young person had any other existing health conditions this was noted at the outpatient clinic and assessed at the pre-operative assessment stage in liaison with a paediatrician. A decision was then made as to the most appropriate pathway for them.
- The children's acute transport service (CATS) was used if a child collapsed outside the hours the RDCEC was open and staff trained in paediatric immediate life support maintained the child until they were retrieved. CATS is a specialised service designed to make intensive care rapidly available to critically ill children in the North Thames and East Anglia regions.
- A paediatric early warning score (PEWS) chart was developed at Moorfields, for the specific patient population. Nurses were trained in its use and it was implemented in the middle of December 2015. Nurses felt supported in the use of the tool and were

knowledgeable about the criteria and process for escalation. Records we checked demonstrated PEWS was being used post-operatively for patients in the day case ward.
- Staff reported that there was a good response from the anaesthetists or paediatricians when clinical concerns were escalated to them.
- A senior nurse told us "PEWS is making nurses realise the importance of observations and has helped them manage escalation better."
- We were told the safer surgery (WHO) checklist was used for all patients going to theatre and we observed its use during our inspection. The trust broke this down into a three step checklist and team briefings prior to and following the procedure.
- We checked five health records and found the checklist had been completed fully in all cases along with surgical count documentation.
- There were no audits of the use of the checklist solely for children's services, however, a general audit completed by the trust of 29 sets of notes between February 2016 and April 2016 indicated poor compliance with the checklist with only 52% of checklists full completed and an audit of the team briefing parts of the safer surgery checklist indicated 69.5% compliance.

Nursing staffing

- The staffing establishment on the day case ward met the recommendations of the Royal College of Nursing standards for staffing levels in children and young people's services (2013).
- An acuity tool was not being used to assess nurse staffing requirements. However, the specialised nature of the service was such that recognised acuity tools would not be appropriate for this service. We were told the throughput of the unit was used to inform the reviews of nurse staffing requirements.
- Staffing requirements were reviewed informally on a daily basis by the paediatric sister and staff were deployed to take into account fluctuations in demand in each of the areas. A minimum of two registered nurses were maintained at all times in the A&E department and the day surgery ward.
- The rosters we examined indicated the planned staffing levels were being achieved consistently.
- There was one whole time equivalent (WTE) vacancy at the time of the inspection and due to reviews of the skill mix within the RDCEC as a whole, the funding was being used to recruit to a new role.
- Funding to provide cover for maternity leave and long term sickness absence was available.
- There were a total of seven play specialists/play workers covering children's services throughout the trust. As a result there were normally four play staff on duty daily in the RDCEC, providing support on each of the floors of the service.
- Parents we talked with told us staff were always available when they needed them and were attentive to the children's needs.

Medical staffing

- Medical staff were at least at ST3 (specialist trainee) level and above.
- There had been some reductions in trainee posts as a result of deanery and local school allocations being reduced.
- Anaesthetic trainee posts had been reduced from six to three and therefore locums were used to manage the gaps in the rotas. However, all locum medical staff had worked at the trust as trainees previously and were therefore familiar with the service and ways of working and their competence had been previously tested.
- There were six WTE medical staff vacancies in March 2016. We were told ophthalmologist vacancies had either been filled or were in the process of being recruited to.
- Consultants were always available within the service during opening hours. Paediatric cover was provided out of hours in a shared rota with Great Ormond Street Hospital NHS Trust.
- Consultants we spoke with said medical staffing levels felt safe.

Major incident awareness and training

- The trust had a major incident plan in place dated June 2015. The trust is termed as 'a category one responder' due to its 24 hour A&E ophthalmic service; however Moorfields is not a designated receiving hospital during a major incident.

Services for children and young people

- There is a responsibility to be prepared for an emergency and the trust had carried out incident management and business continuity management training during 2015. Representatives from paediatrics had attended the training.
- Senior staff we talked with were aware of their responsibilities in the case of a major disruption to services.

Are services for children and young people effective?

Good

We found services for children and young people were effective because:

- Care and treatment provided was evidence based and medical staff contributed to the development of national standard setting and guidance.
- Surgeons examined the outcomes of care and treatment they provided and where possible carried out benchmarking against other providers.
- The trust contributed to national ophthalmology database audits and local audits of practice were completed.
- Staff had access to training to maintain and develop their knowledge and skills.
- Patients had access to a wide range of professionals appropriate to their needs and there was good multi-disciplinary working.

Evidence-based care and treatment

- Policies and guidance had been developed in line with current best practice including guidance from the National Institute of Health and Care Excellence (NICE), the Royal College of Ophthalmologists (RCOphth) and the Royal College of Paediatrics and Child Health (RCPCH).
- All clinical guidelines were available for staff on the trust intranet and staff told us there were no difficulties in accessing these.
- Consultants had contributed to the development of national best practice guidelines published by the Royal Colleges. For example, a consultant ophthalmologist was a member of the guideline development group for joint guidelines for retinopathy of prematurity produced by the RCOphth and RCPCH, and guidelines for abusive head trauma and the eye produced by the same bodies.
- Some of the consultants were undertaking very specialist surgery and had the opportunity to develop practice in their specialist area. For example, Moorfields, in conjunction with Great Ormond Street hospitals treat the majority of children with microphthalmia and anophthalmia (small eyes and no eyes).
- A consultant had published extensively on vitreoretinal surgery. Patient safety incident reporting in vitreoretinal surgery had been introduced at Moorfields and a recent publication indicated that this had resulted in changes to clinical practice.
- A research study was being undertaken to examine the efficacy of corneal collagen crosslinking (CXL) in children with keratoconus funded by the National Institute for Health Research (NIHR). NICE had approved the use of CXL provided a study of outcomes was undertaken and encouraged further research on outcomes in children and young people. The trust was therefore assessing the effectiveness of new treatments for eye conditions in children to contribute to the evidence base. Keratoconus is an eye condition in which the normally round dome shaped clear window of the eye (cornea) progressively thins causing a cone shaped bulge to develop.

Pain relief

- A child friendly pain assessment tool (the Wong-Baker FACES scale) was included in the day surgery pathway documentation and we saw it being used in the assessment of children's pain in the recovery area and on the day case ward.
- Pain assessment was also undertaken at triage in the children's A&E using the same tool.
- Parents we talked with said that staff checked children's pain and one person whose child had experienced some pain told us they felt it had been managed very well. Children we talked with following surgery told us they had not had any pain.
- An audit of pain relief following squint surgery was being undertaken.

Nutrition and hydration

- Children and young people admitted to the day surgery ward were provided with information about eating and drinking pre-operatively prior to admission and their parents were reminded about this when staff contacted them the day prior to admission.
- Children and young people were able to drink clear fluids until 6am on the day of surgery if the procedure was taking place in the morning and up to 11am for procedures in the afternoon.

Patient outcomes

- Benchmarking against the RCOphth quality standards and quality indicators for ophthalmic care and service for children and young people had been undertaken and an action plan developed to increase awareness of the family support service as a result.
- The service was undertaking benchmarking with the British and Irish Strabismus Association to examine complications of surgery for strabismus (squint).
- An audit of the outcomes of strabismus surgery, indicated a complication rate from January to December 2015 of 0.23% which is better than the national standard of <2.2%.
- Ophthalmic consultants and anaesthetists told us of benchmarking meetings they attended at other specialist trusts.
- A range of local audits had been undertaken during 2015/16 and the action plans developed from these were monitored at the paediatric services meetings . Examples included an audit of paediatric attendance out of hours in A&E and an audit of a pilot of telephoning patients who did not attend their outpatient appointment.
- An audit of care in A&E was completed using an Institute for Healthcare Improvement guideline and RCOphth critical incident guidelines which found optimal clinical management in 90% of patients and no clinical harm to any patient. An action plan for improvement had been developed. One surgeon had undertaken a comparison of outcomes following two different tube implants they had used in the treatment of paediatric glaucoma. A report was produced comparing the outcomes for patients. The success rates for both devices were compared with published studies and compared favourably with those previously reported in children.
- An audit of children undergoing surgery for squint had been undertaken and as a result pain relief following surgery was being reviewed. Audits of pre-operative fasting were also being undertaken.
- Orthoptists and optometrists were also undertaking audits on a regular basis. For example, we were shown evidence of an audit of the value of different treatments for amblyopia (lazy eye) both in regard to outcomes for the patient and the patient experience. This was being submitted for publication.
- Audits of the children's vision clinics had been completed using a global trigger tool and a comparison of issues identified at each of the sites was undertaken with an action plan for each.

Competent staff

- All nurses within the RDCEC were registered children's nurses except in recovery where there was only one registered children's nurse. However, the other nurses in recovery were very experienced with children.
- All the anaesthetic nurses had completed the advanced paediatric life support (APLS) course.
- As of May 2016, 84% of staff had undertaken paediatric basic life support within the previous year and 75% had undertaken paediatric immediate life support (PILS). This was above the trust target of 80%.
- Training in helping visually impaired people was provided as part of the mandatory induction training. Compliance was 96.43% against a target of 90%. In addition, video based training had recently been introduced and 38% of staff had attended the training. The trust target for attendance was 30%.
- 100% of nurses and nursing support staff had received an annual appraisal and compliance for other staff was over the trust target of 80%. A total of 83% of staff in children's and young people's services had received an annual appraisal.
- There was an electronic flagging system to remind staff when appraisals were due.
- All of the clinical staff we talked with told us there was good access to training both internally and to attend external courses. The paediatric matron told us they had never been refused funding for themselves or a member of their team.
- The head orthoptist told us they were well funded for training, they were able to access national ophthalmology courses and all 35 of their staff were able to attend at least one external meeting a year.

- There were weekly Monday and Wednesday morning teaching sessions which were attended by all disciplines. Staff found these very valuable.
- Study days were also held at weekends and staff attending these were able to claim their time back for study they attended outside working hours. They talked enthusiastically about glaucoma study days and paediatric study days.
- A nurse told us about a study day they had attended to improve their knowledge of autism in children and following this had developed an information leaflet for other staff about autism.
- However, there was no practice development post within children's services and we were told it was difficult to develop advanced nurse practitioner and clinical nurse specialist roles as a result of this. Due to the specialist nature of the services, bespoke courses were required and training would need to be undertaken in other departments within the service for these roles.
- We talked with two student nurses who told us they had been allocated a mentor and had a link lecturer. They were able to spend the required time with their mentor and felt well supported by the placement coordinator. One of them said, "As soon as we walked through the door our mentor was there to greet us." They knew how to report a concern through the university.
- Medical staff reported they had good access to training. There was a budget and study leave for trainee staff and consultants who carried out only NHS work also had a study leave allowance.
- Processes were in place for medical staff revalidation and there were records indicating compliance.
- Play workers also reported good access to training and development.

Multidisciplinary working

- We observed good multi-disciplinary communication during our inspection in all areas of children's and young people's services.
- One member of staff said about the outpatients department, "The fact that all disciplines are in one area and the rooms are multi-functional helps multi-disciplinary working."
- A family support specialist said the multi-disciplinary working was excellent. They said, "I feel part of the team."
- A multi-disciplinary briefing meeting was held each morning prior to the start of the clinics. This enabled staff to problem solve issues with individual clinics and try new ways of working to improve flow.
- We saw examples of the development of clinics to ensure efficient and effective use of the skills of different professionals. For example, some patients were managed by the orthoptist and optometrist and did not see a doctor, whilst in other clinics patients were seen by an optometrist and paediatrician.
- A parent we spoke with talked about the doctor consulting with their colleagues as their child had a complex condition and how they were impressed with this. They said they felt the whole team had been involved in identifying the best way forward and they had benefitted from a pooling of the expertise.
- There were no formal multi-disciplinary team (MDT) meetings to discuss the care of children but most clinics were multi-disciplinary and clinicians liaised with each other to discuss and agree patient care pathways. We observed this occurring during the inspection.
- Most imaging services were available within the RDCEC but when required, children and young people were accompanied by a children's nurse for imaging within the adult service.

Seven-day services

- The children's consultant led A&E service was open Monday to Friday from 9am to 4pm with paediatric triage until 5pm. Outside of these times children and young people could access the adult A&E department if necessary.
- The day surgery ward was open Monday to Friday from 7.30am to 7pm and surgery was normally completed by 4pm to allow time for children to recover and be discharged home.
- The outpatient's clinics ran from 9am to 6pm Monday to Friday.
- No staff were available out of hours with training in advanced paediatric life support (APLS) however staff in A&E had training in paediatric immediate life support (PILS).

Access to information

- There had been some issues with the availability of health records and high use of temporary notes caused by poor tracking of records, following changes to the

library system. However, following liaison with the medical records staff, the process had improved and we were told by staff that notes availability was generally good.
- Policies and guidelines were available on the intranet and were generally up to date.
- Staff found guidelines easy to access.

Consent

- Staff were aware of the requirements relating to consent. They had knowledge of the need to assess the competency of the child or young person to give consent themselves, to ensure that informed consent was obtained appropriately. They were familiar with the 'Gillick' competencies and 'Fraser' guidelines.
- Parents told us the procedures had been fully explained to them and their child and staff had explained to their child in a way they could understand. A parent said, "It was very well explained and there was plenty of information."
- A young person we talked with said they had understood the requirement to give consent. The procedure and why it was required had been fully explained and they had signed the consent form alongside their parent.
- Consent forms had been fully completed in all the care records we examined.

Are services for children and young people caring?

Outstanding ☆

We found caring was outstanding because:

- Staff demonstrated through their behaviour and the relationships they developed with the children and young people using the service, their total commitment to ensuring they had a positive experience. They tailored their approach to the needs of individual children and young people and went the extra mile for them when providing care and support. They turned what a patient described as a "scary" place into a cheerful and friendly place to be.
- In all areas of children's and young people's services, patients and their parents were overwhelmingly positive about the kindness and compassion of staff. People valued their relationships with staff and felt they were exceptional in the care and support they provided.
- Complex conditions and procedures were explained to children and young people in a way that enabled them to gain a full understanding of their treatment plan and take an active role in decision making.
- Creative ways to tailor information and make it accessible for children were utilised, including an internet resource to provide information about eye conditions and a virtual eye hospital with interactive features. The quality of written information was excellent and catered for the needs of different age groups and levels of understanding.
- Families felt supported emotionally by staff they came into contact with at the service and the family support service provided an additional service for those with additional needs.

Compassionate care

- We observed care in all areas of the RDCEC and throughout our observations, the caring and attentive nature of the staff was apparent. Staff were quick to notice children who required some additional support or an anxious relative who needed a chat and some quiet time.
- Parents and children were overwhelmingly positive about the kindness and compassion of staff. A parent said, "It's absolutely outstanding. The staff are receptive, caring, experienced and attentive." "Everyone from the junior staff right up to the professor."
- A parent in the outpatients department said, "The nursing staff are fabulous and all are lovely. (Name of child) gets very anxious about blood tests, but staff are very calm and friendly and they bring out the iPad to distract (the child)." Another parent mentioned the play team being very good at using distraction for their child who had a needle phobia.
- Some of the children and young people had visited the RDCEC on a number of occasions and staff remembered them. This gave the children and parents confidence in the service. For example, a parent said, "The play staff are fantastic with (the child). (The child) knows he can talk to them and knows there is a book to remind him about what happens."

Services for children and young people

- In addition to the friendliness of staff, a common theme from children and their parents was that staff were calm and this helped them when they were anxious. Children and young people talked about going to theatre as being a particularly anxious time and commented on the kindness and understanding of the anaesthetists and theatre staff. A young person said, “The theatre staff and anaesthetist were lovely.” “They sort of calmed me down a bit.” Parents also said the anaesthetist put them at ease.
- A parent was able to accompany their child to theatre and go to recovery to collect them with staff, when the child was ready to return to the ward. Staff accompanied parents back to the ward when they had left their child in theatre.
- Play staff were available on each of the departments including A&E and outpatients. They quickly engaged with children as they came into the department and found activities which they could become involved in. They had a cheerful and relaxed manner and spent time on a one to one basis with children or gathered together a group of children to participate in an activity. In this way children did not become anxious or restless whilst waiting.
- The NHS Friends and Family test in September 2015 showed the day surgery ward and the children’s A&E department scored over 95%
- The national children and young people’s survey carried out in 2014 indicated that the trust performed ‘better’ compared with other trusts for 22 of the 34 questions for questions relating to ‘caring’.

Understanding and involvement of patients and those close to them

- Parents and children were aware of the plans for their care and treatment and were fully involved.
- Parents and children we talked with told us they had received full explanations from staff and this was supported by written information. One parent said they were shown their child’s scan results on the computer and the improvements over time had been shown to them.
- Staff talked with the children and young people using language they could understand and fully involved them.
- Parents and young people were aware of the plans for their care and treatment and they told us that when there was uncertainty as to the long term plan, this was explained to them and, “Things are explained as we go along.”
- Parents said they were given the telephone number for the ward or the department to call if they were uncertain about anything. When they had called they were straight through to staff who could explain issues or provide reassurance.
- High quality patient information leaflets were available for children and their parents. The leaflets were produced in versions for younger and older children as well as information for parents. For example, there was a booklet for parents entitled, ‘Your child’s general anaesthetic’ which was written very clearly, in language the average adult reader would understand. This included colour photographs and the role of the parent in the anaesthetic room was fully explained. In addition, a booklet was available for younger children, entitled, ‘Rees Bear has an anaesthetic’ which was of similar quality. Information leaflets about different eye conditions and procedures were also available
- The trust had an internet resource designed for children and young people, giving information about eye conditions. It was divided into three different age groups and also had an animated eye, a virtual children’s eye hospital and other interactive features suitable for children.

Emotional support

- Parents told us they felt they and their child were emotionally supported by the staff who always would listen and had time for them.
- During the inspection we noted the paediatric matron was called to the outpatients as some bad news had to be broken to a family. The matron went to sit in with the doctor and provide additional emotional support to the family.
- There was a family support service within the RDCEC outpatients department. The family support specialists were qualified teachers with experience of working with children with visual impairment. They provided support to patients and their families in outpatients and on the day surgery ward. This might be emotional support to families who had found out they had a child with a

serious disease, educational support and liaison with schools when children had problems at school, child development issues when a child might need additional input with vision impairment.
- The family support service also offered to introduce families with children with similar conditions particularly when they were rare conditions.
- The family support service also included the Eye Care Liaison Officer (ECLO) role and they completed the documentation related to the certificate for visual impairment. They identified that this was a particularly emotional time for parents and it was important to be sensitive to the support people required.
- Most of the families we talked with were aware of the family support service but one parent told us they had not been told about the service initially and had difficulties contacting them. We saw an action from a recent audit had identified the need to increase awareness of the service.
- The service had been successful in obtaining funding for a counsellor to provide additional support and were in the process of recruiting to the post.

Are services for children and young people responsive?

Good

We found responsive was good because:

- The individual needs of children and young people were identified and care was tailored to take account of these needs. The service had processes to identify the needs of children with complex needs and make adjustments to ensure they had as good an experience as possible.
- Patient pathways had been mapped and steps taken to improve the flow of patients through the outpatient's services to reduce repeated attendances and waiting times as much as possible.
- Children and young people had access to age appropriate recreational activities and the play team were available in each area providing individual support which was sensitive to children and young people's wishes.

Service planning and delivery to meet the needs of local people

- In response to the increasing number of patients attending the children's A&E the number of consultants covering A&E had been increased. The service had carried out an audit of the attendances of children at the main hospital A&E department when the children's service was closed, to identify the demand for the service. This indicated there was a high proportion of patients attending with non-emergency conditions and the service was considering how this was best managed. This included redirecting of some patients to the children's service the following day.

Access and flow

- The children's A&E department acted as an emergency department and also as a walk in centre and treated patients with a wide variety of eye conditions.
- Patients attending the children's A&E were seen within the four hour target for emergency services and the journey time for patients during 2015/16 averaged 105 minutes.
- 87.9% of patients requiring elective surgery were treated within the 18 week target for referral to treatment times between August 2014 and July 2015.
- Between August 2015 and April 2016 the cancellation rate for elective surgery varied between 2% and 16%. There were no breaches of the 28 day threshold for rescheduling. We talked about the reasons for the high number of cancellations and were told that the majority of patients were cancelled by the parent, due to the child being unwell or a member of the family being unwell. Due to the nature of the surgery and the day case service provided, children were generally required to be otherwise fit at the time of the surgery.
- When patients had a long distance to travel for elective surgery, where possible some of the pre-operative assessment was carried out by telephone and in some cases the pre-operative assessment was carried out the day before surgery to allow the assessment and surgery to be undertaken at one visit. Most families were able to stay in the charity run family accommodation on the top floor of the RDCEC on the intervening night. Where children required to be reviewed the following day, this accommodation was also available to be booked for the night following the surgery.
- One parent suggested their time on the ward could have been reduced if they were allowed to insert the required eye drops themselves prior to attendance as they were

asked to arrive at 7.30am and their child frequently did not go to theatre until 11am. However, this would not have allowed the child to be checked prior to the start of the theatre list.

- We found considerable variations in the number of patients undergoing surgery on different days of the week and therefore fluctuations in the admissions to the day case ward. For example, the number of patients on a Tuesday and Wednesday was low and there were high numbers on a Friday. We talked with the divisional leadership team about this and they told us they had considered ways to smooth the flow but the situation was complex due to surgeons who were only on site on certain days and difficulties in coordination of their other responsibilities such as outpatient clinics.
- Staff told us they had particular concerns about the overbooking of patients for surgery on a Friday a few months previously but they had worked closely with the booking team to ensure limits were put on the booking of patients. Although Fridays continued to be very busy there had been improvements and the situation was being managed.
- Two operating theatres were allocated for paediatrics and there was a dedicated children's recovery area. However, when there were no children for theatre or a short paediatric theatre list, the theatres were utilised for adult patients. Overall theatre utilisation for the two theatres averaged over 80% at the end of 2015 but, from the data provided, it was not possible to determine the amount of time the theatres were utilised for children..
- The entry to theatres was adjacent to the day surgery ward and was optimally placed for quick and easy transfer to theatre.
- There were two floors of outpatient clinics. The consulting rooms were multifunctional allowing efficient use of the space available. All of the professional groups patients needed to see in outpatients were therefore able to be accommodated in the same area, thus reducing the journey time for patients when they needed to see more than one professional.
- Patients were able to see all the professionals at the same appointment, essentially creating a one-stop clinic. This increased the time they spent in the department but reduced the number of visits required.
- Most of the clinical imaging took place within the children's centre but there was one piece of equipment which was only available in the main hospital and this necessitated a visit to the main hospital for a small number of children.
- Average journey time for children attending outpatients was 88 minutes between April 2015 and March 2016. The trust did not collect data on waiting times.
- Parents told us waiting time was variable and when they attended they expected to be in the department for approximately two hours. However, they accepted this as they appreciated the fact they could "do it all in one day." A parent also said staff were accommodating when arranging appointments.
- The patient pathway through the outpatients department had been identified as an area for improvement by patients and staff and as a result had been modified for some patients groups and a multi-disciplinary briefing meeting was held each morning prior to the start of the clinics. This enabled staff to problem solve issues with individual clinics and try new ways of working to improve flow.
- Audits of non-attendance at outpatients clinics had been completed in 2014 and a more specific audit was completed in the last quarter of 2015 to identify reasons for non attendance at two specialty clinics for children with long term eye conditions. The most recent audit did not identify any common themes or issues.

Meeting people's individual needs

- The environment within the RDCEC was light and spacious although the central atriums, whilst contributing to this, also allowed sound to travel between the floors. As a result, the environment in outpatients could be noisy at times particularly when it was also busy on other floors. This was highlighted as an issue for some children and young people with autism.
- The day surgery ward had a mix of four bed bays and single and double rooms. As a result, patients could usually be accommodated with others of the same gender or a similar age according to their needs and preferences.
- A young person commented on the environment on the ward, "Everywhere is so bright and happy and child friendly." "I was really scared about coming in but the environment and the staff are so cheerful; it doesn't feel like I expected a hospital to be, and it made it less scary."

- They also mentioned the pictures on the ceiling in the anaesthetic room which they said they were able to focus on when they were unable to concentrate on anything else.
- There were lots of toys and activities available to occupy children and young people while they were waiting to be seen and the play staff ensured people were offered age appropriate activities.
- Following return from recovery children were offered drinks, a choice of sandwiches, cereals and ice cream. We observed this for patients returning from surgery whilst we were on the ward.
- Children and young people we talked with said there was a good choice of sandwiches and staff checked with them prior to admission about what they liked. One parent said, "He loves the food. (The child) is made aware of what's on offer and can choose what they want."
- However, one parent told us that although they were always asked about their child's preferences prior to admission, they were not offered any food whilst they were on the ward. We talked with staff about this and there was genuine concern as to how this had happened, as they said children must eat prior to discharge and it was routine practice to offer them something, even when parents had brought their own food. The paediatric matron told us they would talk with the parent and try to identify how this had occurred.
- A flagging system was in place to identify children with a learning disability and/or autism. Staff recognised these children needed adjustments to be made for them and they told us the flagging system enabled them to identify this and check the notes to ensure they took their individual needs into account.
- We were told and we found, children and young people with a learning disability and/or autism were scheduled in such a way as to reduce their waiting time whether they were attending outpatients or the day surgery ward.
- We talked with three parents of children with autism and they told us staff were sensitive to their child's needs. One parent told us their child had been given a double room to reduce the noise. Another parent said, "They understand and do their best to keep (the child) happy." "They do as much as possible away from the bed as (the child) associates the bed with things they don't like." All the parents said the staff ensured that waiting times were kept to a minimum for their children.
- We saw copies of a patient passport for people with a learning disability, which had recently been introduced. It was designed to be completed by parents to identify what was important for staff to know about the child such as how they preferred to communicate, things which made them anxious or distressed, how they would tell staff if they were in pain and their support needs in aspects of daily living. A parent told us they had been asked to complete a passport for their child who had been admitted for surgery.
- There was access to translation services for patients and parents for whom English was not their first language and staff we talked with were familiar with the process.
- The children's service cared for children up to age 16 although there was some flexibility for children with complex needs. When young people transferred to the adult service, in most cases they remained under the same consultant, thus reducing the impact of transition.
- The family support service was able to provide support during the transition process.
- A transition policy and flow chart were in place with clear guidance on the process to ensure there was appropriate support and communication when young people transferred to adult services.

Learning from complaints and concerns

- There were only two complaints within the RDCEC during 2015. These had been investigated and responded to appropriately.
- A parent in the outpatients department told us they had seen a doctor previously who had not engaged with their child and wasn't happy when they asked questions and challenged the doctor's recommendations. They made a complaint about this and the doctor apologised to them.
- Complaints were discussed at the paediatric services meeting to ensure learning took place and any lessons were communicated throughout the service and across the satellite areas.
- Staff were aware of the action to take if someone raised a complaint or a concern with them and said patients would be encouraged to involve the patient advice and liaison service (PALS) where appropriate.
- Staff rang all patients who had attended the day surgery ward 24 hours post-operatively to check on their recovery, to answer any questions they might have and to ask for comments for improvements.

Services for children and young people

- We saw comments cards in the A&E department and staff encouraged patients to complete them prior to their discharge.
- A display board on the day surgery ward included a 'You said, We did' section which gave information on how the service had responded to feedback they had received from patients.

Are services for children and young people well-led?

Good

We found services for children and young people were good for well led because:

- There was strong clinical leadership and staff felt well supported in their roles.
- There was a comprehensive programme of research and development with collaboration and support from national bodies.
- There was a culture that put children and young people first.
- Clinical governance processes were in place

However, we also found:

- There was no clear strategy for the future development of the service.
- There were no clear quality targets or priorities for the service.
- Although the risks we found during the inspection reflected the risks identified on the risk register, some items had been on the risk register for over two years with little visible progress being made.
- There was no annual children's report to the board.

Leadership of service

- The senior leadership team for children's services consisted of a service director, service manager and matron.
- Staff told us they felt well supported by their managers. Nurses told us the paediatric sister and matron were very supportive and they felt their contribution was valued.
- Staff on the day surgery ward told us there were ward meetings every month and they felt able to raise issues for discussion.
- The leadership team demonstrated an awareness of the issues and constraints within the service. Staff were enthusiastic and passionate about further developing the quality of services.
- We were told that following a review of clerical and administrative support there had been a reduction in administrative staff. Concerns had been raised about this and as a result, the staffing levels had been increased but shortage of staff remained an issue. Although some staff felt their concerns were not being taken forward, we found an awareness of the issues amongst the leadership team.
- Staff told us the new Chief Executive had visited all the areas within the last month. They were aware of the management team having moved back to the main building and welcomed this.
- A weekly trust newsletter was circulated to all staff to keep them up to date with changes within the trust.

Vision and strategy for this service

- The last paediatric service review had been undertaken in 2011 and there had been considerable developments in the service and an increase in demand since that time.
- Divisional leaders identified the increases in demand for both A&E and outpatient services and that the service needed to grow to meet the need.
- However, there was no concrete plan for how this would be managed. It was suggested that more services could be moved to satellite sites and there was a reliance on plans being advanced for a new hospital build.

Governance, risk management and quality measurement

- Clinical governance formed part of the paediatric services meetings which were held every two months. We saw evidence of representation from each professional group at the meetings and discussion of incidents, complaints and risks.
- We were told that any issues which could not be resolved at this level would be escalated to the trust clinical governance meetings.
- A risk register was in place which identified the major risks to the service. We noted some risks had been on the register for over two years with little visible progress. For example the issue we identified regarding the safety of the barriers in the central atriums had been put on the risk register in 2011 and was still rated as an amber

risk and no further action to reduce the risk had been identified. A risk related to inadequate numbers of clerical staff had been identified in 2012 and was still open. However, the risks on the risk register reflected the risks we identified during the inspection.
- Clinical governance half days were held every three months and these were well attended. They were used to discuss audits, incidents and complaints and disseminate information to staff.
- Staff told us that communication was received about incidents and improvements in a variety of forms including team briefing and emails.
- Staff were not aware of any trust quality priorities or monthly reporting against quality indicators.
- There was no annual children's report to the board although there were six monthly reports on safeguarding children.

Culture within the service

- Staff were proud to work in the trust and talked about the "Moorfields way" as their commitment to improve the care provided.
- One member of staff said, "Everyone takes a huge pride in working here, including the secretaries and clerks and other non-clinical staff."
- Staff felt all patients were treated equally and said they felt the care people received was excellent. They said they were continually looking at how they could improve.
- We talked with one member of staff who had moved from overseas and they felt they had equal opportunities for development.
- Staff also felt they were encouraged to develop and generally felt their views were listened to.
- One consultant identified some difficulties with relationships within the service due to established networks.
- The progression of expanded nursing roles within children's and young people's services was slow in comparison to other areas although there was significant experience and expertise amongst the body of nurses. Priority had been given to the development of other professional's roles which were perceived to be of lower risk.

Public engagement

- There had been involvement of children through open days and focus groups when the RDCEC was built and we were told children had chosen the wall colours on each of the floors.
- Children and young people had been involved in the "In your shoes" consultation process during the introduction of the "Moorfields way" initiative to improve patient experience.
- The service had completed a number of surveys of children and young people to obtain their views on a range of issues relating to the service such as transition to adult services and also for gaining general satisfaction data. They utilised a computer based survey that used animated characters, such as Fabio the Frog, to guide patients who may have difficulty completing a paper questionnaire, including those with an injury or disability. The service had adapted the survey to make it specific to the trust in that Fabio loses and regains his eye during the survey.
- In response to the results of one survey an enhanced range of recreational materials for teenagers had been provided.
- However, the service did not use the Department of Health 'You're Welcome' toolkit to assess 'young people friendly health services'. This would have enabled the service to identify whether further young people friendly adaptations would be beneficial to improve patient experience.
- Children and young people were consulted in the development of all the patient information leaflets for children's and young people's services. They were distributed to children of the appropriate age in outpatient's clinics, their comments recorded and changes made in response.

Staff engagement

- Staff were aware of the weekly trust newsletters and told us they provided information on current issues for the trust.
- All the staff we talked with were committed to the trust and felt they were informed of the issues and developments within the service.
- Staff expressed the view that the movement of the management team into the main hospital building suggested a willingness of the senior managers to engage with staff and hoped this would result in the team having a more regular presence in the clinical areas.

Services for children and young people

Innovation, improvement and sustainability

- A clinic had been set up for children with hearing loss to investigate visual impairment in these children. This had been evaluated and the results were to be presented at the International Orthoptist Congress.
- A clinical research facility was situated within the RDCEC building and at the time of the inspection, 11 research studies related to children were being undertaken. This included national and international research including randomised controlled trials.
- Examples of research directly influencing practice within the service included the development of a new device to facilitate child friendly methods of measuring visual fields and research into treatments for amblyopia (lazy eye).
- Medical staff working in children's and young people's services carried out a wide range of research and audit to develop and improve clinical practice. Much of this was published in national journals and they were regarded as leading in their field of practice.
- A consultant had worked with the Armenia Eye Care Project to develop a tertiary referral paediatric vitreoretinal centre for children in Armenia and neighbouring states. Additionally, in partnership with a consultant in Los Angeles, telesurgery was developed to provide remote surgical mentoring and support.

Outpatients and diagnostic imaging

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

Information about the service

The outpatients and diagnostic imaging service at Moorfields Eye Hospital offers a range of specialist outpatient eye clinics, including clinics for glaucoma, medical-retinal, external diseases, vitreoretinal, uveitis, adnexal and contact lenses. Patients can access expertise from eye specialists including optometrists (who complete eye health and vision assessments and provide prescriptions for glasses if needed), orthoptists (specialists in defects of eye movement) and ophthalmologists (a doctor specialising in medical and surgical eye conditions). In addition to x-rays and CT scans, other specialist investigations are available. For example retinal and anterior segment photography, optical coherence tomography scans, indocyanine green angiography and wide field fundus imaging. There were 294,064 outpatient attendances between April 2015 and March 2016.

We visited the outpatients and diagnostic imaging services at Moorfields Eye Hospital City Road site for four announced inspection days and one unannounced inspection day. During our inspection we inspected all clinic and diagnostic imaging areas and spoke with 29 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the outpatients and diagnostic imaging leadership team, and 13 patients and relatives. We reviewed 18 patient records and checked many items of clinical and non clinical equipment.

Summary of findings

The outpatients and diagnostic imaging service requires improvement. Outpatient clinics were frequently overbooked, resulting in clinics overrunning and long waiting times for patients. These problems were not formally monitored despite the leadership team identifying long waiting times as a contributory factor to an issue documented on the risk register. This meant they could not effectively manage or monitor the risk. The outpatients environment was identified as unsuitable however there were no clear short term plans to improve this prior to rebuilding the hospital on a new site. Staff did not have full confidence in the leadership team and told us they were not visible in the department.

We did not see evidence that vulnerable patients were flagged electronically when they arrived in clinic, although the trust told us this system was in place, and would not be identified as having specific needs if their full medical records were not available. A clinic welcome leaflet asking patients living with dementia or those with a learning disability to identify themselves to staff was not a reliable or appropriate system to address this.

Patients records were often completed poorly, for example scribbling through errors and several illegible records were seen. Some notes lacked patient identifiable information and it was unclear who had written many entries as no signature or printed name of the staff member was documented.

Outpatients and diagnostic imaging

Patients commented that signage to different clinics was not always clear and we observed patients having difficulty locating some areas, such as clinic 11. Patients also commented that font sizes on hospital documentation was too small and we saw patients struggling to read certain documents, such as the Friends and Family Test.

However, the service was meeting the 18 week referral to treatment time target and patients could access diagnostic imaging with ease, including walk in slots on the same day as their clinic appointment. Patients were mainly positive about their interactions with staff and praised the clinical care they received.

The service benchmarked outcomes against other eye hospitals globally and had an embedded multidisciplinary approach, including liaison with other teams within the hospital and colleagues internationally. There was regular audit activity to ensure compliance against best practice guidance and evidence of significant contribution to research.

Are outpatient and diagnostic imaging services safe?

Requires improvement

The safety of the outpatients and diagnostic imaging departments required improvement because patients were not always protected from avoidable harm.

- Staff were unable to describe examples of recent incident feedback or learning points, despite information provided by the hospital indicating dissemination of this information occurred through staff meetings and training days. Additionally, some staff did not know about duty of candour principles, particularly relating to near miss situations.
- Some clinic waiting areas were extremely warm at times and, although temperature monitoring took place, actions did not fully address the heat.
- Some patient records were poorly completed, with missing signatures, unfinished entries and lack of patient identifiable information. Some notes entries were illegible. This was evident throughout the outpatients clinics, including in the botox service, and could place patients at risk.
- Availability of 'floorwalkers' to monitor patient wellbeing in waiting areas was limited. Staff throughout the outpatient clinics were busy and told us they rarely had time to take their full breaks during their shift.
- No emergency buzzers were available in the radiology department, which could delay staff accessing help in an emergency.

However:

- Staff were proactive about reporting incidents and could describe when incident forms should be completed. Incidents were investigated appropriately.
- Outpatients and diagnostic imaging staff had good knowledge about safeguarding and a high proportion of staff (94%) had completed safeguarding adults training.

Outpatients and diagnostic imaging

- We observed suitable infection prevention and control procedures, including hand hygiene, staff bare below the elbows and suitable cleaning schedules in place. The outpatients and diagnostic imaging environment was mainly visibly clean throughout.
- Radiation safety processes, including access to lead vests and radiation monitoring, were suitable. The environment in which radiation was used was fit for purpose and protected staff and patients from unnecessary exposure to radiation.

Incidents

- There were 821 incidents reported by the outpatients and diagnostic imaging departments between the start of October 2015 and the end of January 2016. Of the incidents reported, 114 related to near-miss events. Staff we spoke with, including administrative and clinical staff, knew how to report incidents and were able to provide examples of incidents they had previously reported, including near miss situations.
- There were 701 incidents that resulted in minor or no patient harm and four incidents that resulted in moderate harm. Two reported incidents resulted in major harm to the patient concerned. One patient's glaucoma symptoms were not followed up for a significant period resulting in glaucoma-related vision loss. For the other patient, an urgent letter from the ocular oncology clinic was not sent for over six weeks resulting in a delay to treatment.
- We saw evidence that incidents were suitably investigated using root cause analysis where appropriate. Examples we were shown demonstrated that appropriate people were involved in incident investigation however one consultant raised concerns that incident investigation did not sufficiently include clinical staff.
- 537 reported incidents were classified under 'clinical documentation' including 185 misfiled or missing patient notes, 113 incidents where patient notes could not be retrieved and 107 reported delays in obtaining patient notes.
- Other incident trends included 116 medicine related incidents, 60 incidents regarding organisation of care, 60 incidents related to clinical management and 26 staff safety incidents.
- There had been no imaging incidents when patients had 'much greater than intended' exposure to radiation and required notification to Care Quality Commission under Ionising Radiation (Medical Exposure) Regulations 2000.
- Some staff told us they received feedback when they reported incidents whereas other told us they only found out when the incident investigation was closed. Senior staff told us there was an automatic alert sent to the person who reported the incident when incidents were closed.
- Senior staff disseminated learning points from incidents during monthly team meetings, in pre-clinic preparation meetings and in clinical governance training days. Clinic staff were unable to provide examples of recent incident feedback or learning.
- Senior staff were aware of duty of candour principles and were able to identify the requirement to be open and honest about any mistakes, and to provide an apology to the affected patient. Some senior staff were unclear if near miss situations needed to be highlighted to patients.
- Junior staff awareness of duty of candour was limited; some staff were unfamiliar with the term although others were able to identify the need to be honest about mistakes concerning patients. Some staff told us they would apologise to patients if an error was made. Junior staff did not identify the need to be open and honest about near miss incidents.

Cleanliness, infection control and hygiene

- Housekeeping teams completed most cleaning tasks and these were often done outside of clinic working hours so there was minimal disruption to patients and staff. Nursing staff were responsible for cleaning equipment and computers. Daily cleaning checklists were used in the clinic bay areas to identify specific cleaning duties.
- Clinic areas we reviewed were mainly visibly clean, however in clinic 11 we saw that the floors were not clean and there was a layer of dust on some surfaces in the waiting and reception areas.

Outpatients and diagnostic imaging

- Cleaning audits of the outpatient areas were completed on a monthly basis. Results from April 2015 to January 2016 showed the 95% minimum accepted cleanliness was met in all but one month (November 2015 scored 94%).
- Housekeeping staff completed deep cleans in outpatients and the imaging departments on a three monthly basis. Deep cleans were also completed if patients with certain infections, such as MRSA, used outpatient or imaging areas.
- Disposable curtains were used in some areas of the outpatients department. We observed that these curtains were dated and had been changed within the recommended six month period.
- Infection prevention and control (IPC) training was completed as part of mandatory training and the trust identified an 80% uptake target. All staff groups throughout the outpatients directorate met this target and an average of 94% of staff had completed this training.
- Handwashing facilities were available within clinic areas and alcohol gel was available within the clinic bays. Alcohol gel was available in specially designed dispensers for patient use at all entrances to the hospital and on entry to each clinic and ward. Alcohol gel was not required for patient use within the clinic bays as patients removing contact lenses must wash their hands instead of using alcohol gel to safely avoid eye irritation.
- Hand hygiene audits were completed on a monthly basis. Results from April 2015 to January 2016 showed the 95% minimum accepted hand hygiene score was achieved in all but one month (June 2015 scored 94%).
- We observed staff cleaning their hands before and after patient contact, as well as usually cleaning equipment after use. However we observed two occasions when staff failed to clean equipment after use.
- Staff working within outpatients were bare below the elbows when working in clinical areas.

Environment and equipment

- Some of the patient waiting areas were very warm. Temperature monitoring was in place in some areas, such as clinic 11 where a temperature checking document was in use. There were five gaps on the temperature checking document during April 2016, and we noted documentations of high temperatures (29 degrees on 4 April, 28 degrees on 5 April and 27 degrees on 20 April) but no actions were documented in the 'Actions Tracking' section of the form. It was therefore unclear if staff in the clinic had taken any steps to address the high temperature. During our unannounced inspection, the air conditioning was working in clinic 11 and the temperature was much more comfortable.
- We were advised by the trust that a building assessment had been undertaken by an external company to examine ventilation flow rates and temperatures. This commenced in December 2015 and finished in June 2016 with recommendations which were being implemented by the Trust's estate department. Furthermore, staff complete estates work requisition forms when temperatures fluctuate and this is promptly actioned by estates. Fans are available at reception and within the clinic bays.
- The automatic doors at the entrance to clinics 12 and 15 became fixed in an open position during our inspection. The doors had come off the floor tracks and were wobbly in their upright position. We observed several patients holding onto the wobbly doors for support as they walked through them, which could place patients at risk of falling. The door was fixed when the outpatients matron contacted the estates team.
- Staff working in medical imaging raised concerns about their reception desk. The desk was narrow which made them concerned for staff safety if patients became confrontational. They were also concerned about protecting patients' confidential information as visitors waiting at the reception desk could see documents when they were on the desk.
- Electro-biomedical Engineering (EBME) staff maintained equipment within the outpatients and imaging departments. Servicing was contracted out to relevant external organisations. We saw evidence that equipment had been serviced at regular intervals and electrical safety had been checked within suitable time periods.
- Resuscitation equipment was available at suitable intervals throughout the clinics. In clinic 4, the nearest resuscitation equipment was available in the accident

and emergency department. All trolleys were sealed with plastic snap locks that were opened on a weekly basis so the contents of the trolley could be checked. We saw there were no gaps on the checking documents.

- Basic personal protective equipment such as gloves and aprons were available throughout the outpatient services. Additional items, for example eye protection, were available in store cupboards and staff knew how to access these.
- Yellow sharps bins were available within clinic areas and were correctly labelled with a date and the signature of the staff member who put the bin together. Staff were expected to dispose of used eye drop minims in yellow sharps bins and we saw this in practice throughout our inspection. We saw one sharps bin in clinic 2 which contained items above the maximum fill line. A hospital audit of sharps bins in November 2015 showed all clinics, apart the vitreoretinal emergency clinic (score of 87.5%), achieved 95% compliance with sharps bins preparation and use.
- Purple labelled sharps bins were available in clinic 1 and 3 to dispose of cytotoxic sharps waste.
- Black general and yellow clinical waste bins were available throughout the clinic areas. We saw waste was appropriately disposed of and bins were emptied before becoming overfull.
- Some chairs in patient areas were unsteady, such as in the corridor outside clinic 5. When patients were sitting down or rising from the seat, the seating moved considerably. During our unannounced inspection, we raised this with the outpatients matron who told us the seat would be reviewed and removed if deemed unsafe. We also noted some chairs in clinic areas which had splits in the plastic seat cover.
- Risk assessments had been completed for all types of imaging used within the hospital. Assessments we reviewed addressed staff safety as well as patient safety.
- A yellow 'controlled area' sign was in use in areas where radiation was used, for example outside the x-ray room. This sign illuminated automatically when radiation was in use.
- Lead vests were available for staff working within radiography and patients undergoing certain investigations.
- There were no emergency buzzers available within the radiography department. This meant staff working in the department would have to leave an unwell patient to raise the alarm in the event of an emergency.
- Staff working within the x-ray department wore dosemeters to measure their exposure to radiation. We reviewed results from the dosemeters for January to March 2016 which showed staff exposure to radiation was within safe limits. Contingency plans were in place identifying what staff should do if the x-ray machine failed to terminate an exposure
- Consumables were stored in various cupboards throughout the clinic areas. Some boxes were stored directly on the floor, such as in clinic 12, and we observed some very disorganised storage cupboards where items were piled up in disarray, for example in clinic 11. There were also heavy boxes stored above head height on top of this storage cupboard, which could pose a manual handling risk to staff.

Medicines

- Medicines awareness training was compulsory for nursing staff working within the outpatients directorate. This training had been completed by 95.9% of nursing staff, which was more than the 80% trust target.
- Doctors completed Prescribing Practice and Formulary for Medical Prescribers training. Hospital data showed this had been completed by 98% of medical staff, including locums. This exceeded the 80% trust target.
- Non-medical prescribers completed Prescribing Practice and Formulary for Non-Medical Prescribers training. Hospital data showed this had been completed by 98% of eligible staff, which was better than the 80% trust target.
- Medicine prescriptions were printed directly from the hospital computer system and signed by staff before being given to patients. Prescriptions were taken to the hospital pharmacy for dispensing.
- Antibiotic guidelines were in place for staff working within the outpatients department. Results from a hospital audit completed in September 2015 showed that 100% of antibiotic prescriptions written within the outpatients departments stated the indication for antibiotics and selected the correct medicine at the right dose and frequency, as per local guidelines.

Outpatients and diagnostic imaging

- A range of Patient Group Directions (PGDs) were in place to guide prescription and use of medicines throughout outpatients, for example for use with patients receiving nurse administered injections. PGDs are a written instruction for the supply and administration of a specified medicine before a doctor arrived.
- All medicines cupboards and fridges inspected were clean and tidy, and fridge temperatures were within the recommended range of 2-8°C.There was an automated temperature recording system in place, which allowed alerts to be sent to appropriate individuals if temperatures went above the desirable range for medicines storage.
- Staff used a range of eye drops with patients during the outpatient clinics. Eyes drops were left out during clinics and staff locked them away in medicines cupboard at the end of each day. Eye drops we checked were in date.
- We saw staff had written on open containers of irrigation and contact lens solutions the date when the solution had first been opened. This meant staff knew when the solutions had been opened and could discard any that had been open for longer than recommended. In one consulting room in the contact lens clinic, we identified three bottles of open solutions which did not have opening dates written on them.
- Emergency oxygen was available in clinic areas. We saw evidence that staff checked the oxygen cylinder expiry dates on a daily basis and cylinders we checked were seen to be in date. An oxygen cylinder in clinic 11 was a third full; we asked staff how much oxygen should be in the emergency cylinder as a minimum. Staff were unsure and told us they only ever checked the expiry date. This could mean there would be insufficient oxygen for use in an emergency if staff did not check the oxygen level in the cylinder and changed it if running low.

Records

- The medical records team located and tracked patient notes. Administrative staff from the clinics collected the records relevant to their individual speciality before the clinics started. Where patient notes could not be located, a temporary file was put together so the patient's clinic visit could be appropriately documented. All previous letters and investigation findings were available to clinicians electronically. Temporary notes were filed in the patient's permanent folder as soon as possible following their clinic appointment. The risk of seeing patients without full previous documentation was recorded on the directorate risk register.
- When clinics were finished, patient notes were transferred to the medical secretaries so any relevant letters or investigation results could be filed. Notes were transferred back to medical records when complete.
- Between January and March 2016 529 patients were seen in outpatients without their full medical records; this represented 0.5% of all patients seen. This was in line with data from the previous year and an improvement from 2014/15 where an average of 1.1% of patients were seen without full medical notes.
- A notes audit completed by the hospital in February 2016 showed that patient records were in good condition, scoring 95-100% in all sections other than the number of notes with the patient's NHS number (40%). These results were better than in other areas of the trust. The notes audit also reviewed the quality of the last clinical entry. Entries scored 100% in ten domains, however results were less positive for the number of records written in black ink (70%), legible entries (70%), documentation of the patient's NHS number (40%) and designation of person making the entry (10%). These results were slightly worse than in other areas of the trust however the medical records audits of 2015 and 2016 showed an improvement in or maintenance of 100% compliance, in 12 out of the 19 record keeping domains.
- An action plan was identified as a result of the audit findings, including communicating areas for improvement to staff. We asked five members of staff about the audit findings and none were aware of the areas for improvement identified.Thetrust advised us thatthe audit result and action plan was shared with all trust staff via the Moorfields staff e-bulletin in March 2016
- We reviewed 18 patient records and found notes to be correctly filed and in good condition. Most notes were completed in black ink and had stickers with all relevant patient identifiable information. We saw some notes entries were illegible and at least five occasions where staff crossed through notes errors but had not signed next to this.

- There were many patient notes where there were multiple entries under the same date but in different handwriting and there was no indication who had completed the different entries as there were no signatures or printed names of staff. We saw few records which had a signature and a printed name of the staff member documented.
- Some clinic notes lacked sufficient detail, for example one clinic review contained the patient's diagnosis and treatment plan but no other details. Other notes contained meaningless phrases, such as "much better performance today", which did not indicate a measureable or comparable outcome.
- In the botulinum toxin (botox) clinic, we reviewed three sets of patient records that had multiple entries that were poorly completed. Botox assessment and treatment documentation was completed on two pages that were stapled together, however a number of these sheets had come apart and the second page (which contained details of the botox treatment given) had no patient identifiable information recorded. Assessment scores (such as the Blepharospasm Jankovic Score) had not been filled in and other sections such as patient diagnosis and response to last treatment were left blank. Other omissions included lack of dates on documentation, no staff signature on a form detailing the botox treatment given and one occasion where patient consent was not documented. We raised our concerns about the documentation in the botox clinic with the outpatients matron who told us the issues would be raised with the staff members concerned immediately.
- Lockable confidential waste bins were available in all clinic areas. We observed staff disposing of confidential documents appropriately in these bins.

Safeguarding

- Training in adult safeguarding was compulsory for all staff and the trust identified an 80% training uptake target. All staff groups, including nurses, doctors and allied health professionals, met this target and there was an average of 94% training uptake across all staff working within the outpatients directorate.
- It was compulsory for all staff to complete safeguarding children training, although staff required different levels of safeguarding training depending upon their role. The 80% training completion target was applicable for all levels of safeguarding children training. Staff groups met this target across the different levels of training, other than level3 training for medical staff (66.7% completed). The trust was compliant with currentguidance on level 3 training, asa rolling trainingprogramme was in place.
- Safeguarding teaching also included some domestic violence awareness training. An additional domestic violence online learning module was available to all staff, however staff we spoke with were not aware of this.
- Staff were able to describe what type of situations might trigger a safeguarding concern. They could explain how to refer to the trust safeguarding contacts and knew to contact the matron in outpatients with any concerns. Staff told us there were very few occasions where they had need to action safeguarding referrals.

Mandatory training

- Staff were required to complete a number of training sessions as part of their mandatory training. Modules were taught in face-to-face classroom based sessions or via electronic learning modules. Topics included basic life support (BLS), risk and safety management, counter fraud, equality, diversity and human rights, fire safety and information governance.
- Staff told us they scheduled mandatory training sessions in with support from their managers to ensure there was sufficient cover while they were away. Staff told us the time was protected and their attendance at training would rarely be cancelled.
- The trust target for adult and paediatric basic life support training was 80% staff completion. Training uptake for adult BLS was slightly lower than the target for medical staff (78.9%) and allied health professionals (78.2%). Training uptake for paediatric BLS was also slightly lower than the target for medical staff (73%), nursing staff (77.8%) and allied health professionals (76%).
- An average of 97% of outpatients directorate staff had completed information governance training. All staff groups met the 95% completion target.
- Training in helping visually impaired people was provided as part of the mandatory induction training. Training compliance across outpatients staff was 95.7%,

against a target of 90%. A topic entitled 'Helping Visually Impaired People' was recently introduced to supplement the induction training. The training had been completed by 48% of staff in outpatients, which is above the target level of 30%.

Assessing and responding to patient risk

- All patients were asked to confirm their name and date of birth, or other identifiable information, prior to undergoing tests or procedures. This meant staff could be certain they were treating the correct patient.
- Folders containing care algorithms for specific situations, such as adult choking and adult asthma, were available on the resuscitation trolleys. Staff were aware of the location of these algorithms and told us they would refer to this information in the event of an emergency situation.
- Staff knew how to summon medical help in the event of a medical emergency. They told us they would begin BLS as soon as possible and fetch the resuscitation trolley to assist the hospital crash team.
- An 'X-ray Local Rules' policy was in place to ensure compliance with health and safety legislation relating to exposure to radiation. The policy was most recently reviewed in November 2015. The Trust Radiation Safety Committee met twice per year to review radiation protection within the trust.
- The Radiation Protection Officer was identified as the Superintendent Radiographer, who was available within the department at all times during working hours (other than during annual leave or sickness). Two Radiation Protection Advisors were located at University College Hospital, London and were available to provide telephone advice on complying with the Ionising Radiation Regulations 1999.
- Staff asked all female patients requiring an investigation where they would be exposed to radiation if there was any possibility that they could be pregnant. If there was any doubt, patients were asked to do a pregnancy test. If the pregnancy test was found to be positive, this would be discussed with the referring doctor to determine whether the investigation should go ahead.
- It was identified that there were times within the radiography department that staff were working alone due to annual leave or sickness. Staff told us this posed a risk to patients, particularly those receiving contrast injections prior to their investigation as some patients have reactions to the contrast. This meant a staff member would have to manage this situation independently until help arrived. Senior staff were aware of this risk and had submitted a business case for an additional member of staff to limit the likelihood of a lone working situation occurring.

Nursing staffing

- Staff met at the start of each clinic to identify roles and plan for the clinic ahead. Some staff started work at 8am to prepare clinic areas for patients, such as moving specialist equipment between clinics.
- Information from the hospital advised that the number of nurses in outpatients was assessed against demand and acuity, and senior staff advised that on a daily basis staff were moved between clinics to ensure that there are appropriate levels of staffing. There were 71.33 whole time equivalent registered nurses funded within the outpatients department and there were 12.92 whole time equivalent vacancies in April 2016. In this month, the department used 3.85 whole time equivalent of Bank staff to partially fill the gaps caused by vacancies.
- A 'floorwalker' was used to ensure patient wellbeing in the waiting areas. This staff member was used to 'keep an eye' on frail patients in waiting areas and to provide assistance to those who needed help moving between different areas of outpatients, such as those visiting the visual fields department from other clinics. Staff told us floorwalkers were only used when staffing levels allowed. During our inspection we identified limited availability of floorwalkers in clinics.
- There were 168.19 whole time equivalent funded posts for allied health professionals, including radiographers and optometrists. In March 2016, there were 6.69 whole time equivalent vacancies. Agency staff were used to backfill 1.89 whole time equivalent vacancies.
- To support the outpatients department, 118.57 whole time equivalent posts funded for administrative and clerical staff. In March 2016, there were 5.14 whole time equivalent vacancies and these were backfilled by 14.08 WTE Bank and agency staff.

Outpatients and diagnostic imaging

- Nursing, clerical and allied health professional staff told us clinics were very busy and they rarely had time for a break. They told us their lunch break was often very short because morning clinics overran and they had to prepare the clinical areas for the afternoon clinics.

Medical staffing

- Each clinic was run by a lead consultant supported by doctors at varying levels of experience; from specialty trainees to clinical fellows. Some consultants closely monitored the work of their junior staff by reviewing decisions made about every patient during the clinic, whereas others delegated work to the junior staff and were available to assist with complex patients or if the junior doctors were unsure.
- There were 112 consultants who worked within the outpatients department, supported by 98 fellows, 55 specialist registrars and nine speciality doctors. There were also two ophthalmic specialists. In March 2016, the department was funded for 130.91 whole time equivalent medical staff, including 8.15 whole time equivalent vacancies. Locum staff were used to backfill 3.86 whole time equivalent of the vacancies.
- During our inspection, we observed sufficient medical staffing in clinics. Consultants and junior doctors also told us there were enough medical staff in outpatients.

Major incident awareness and training

- Staff told us that the most likely incident to affect outpatients and diagnostic imaging was disruption to travel to the hospital, for example due to severe weather or a terrorist incident. They told us that in this case, patients would be advised not to attend the hospital unless for emergency treatment.
- Senior staff acknowledged the wider role of the hospital in the event of a major incident, for example a major accident which resulted in a high number of eye related emergencies. They told us the hospital would cancel non-urgent clinics if necessary and staff would be redistributed to support the work of the emergency department.

Are outpatient and diagnostic imaging services effective?

Care provided by the outpatients and diagnostic imaging departments was effective. We found:

- Local protocols were evidence based and reflected current 'National Institute for Health and Care Excellence' (NICE) guidance. Local audits were completed to assess compliance with best practice guidance.
- Patients accessed new and innovative treatments through a range of research studies which were being completed at the hospital.
- We saw evidence of embedded multi-disciplinary working, including liaison with other local services and colleagues globally. The service also benchmarked activities and interventions against other eye hospitals globally.
- Staff received a trust and local induction upon starting work in the department. There were clear competencies that had to be signed off for staff working in different roles and opportunities for learning and development.
- There was evening and Saturday availability of some outpatient clinics.

However:

- Between April 2015 and March 2016, 13% of patients had 'unoutcomed' appointments.
- Some staff groups in outpatients and diagnostic imaging did not meet the 80% target appraisal completion rate.
- Opening hours in diagnostic imaging departments were limited in comparison with clinic running times which meant some patients could not access their services during their clinic visit, for example patients attending a clinic on a Saturday.
- Paper-based referrals were received and there was no system available to receive referrals electronically. There was no method to monitor or audit referrals once received therefore they could be lost or delayed without staff realising.

Evidence based care and treatment

Outpatients and diagnostic imaging

- We saw evidence that local protocols for managing certain conditions were based upon current 'National Institute for Health and Care Excellence' (NICE) guidance. For example, the local policy for scheduling aflibercept injections for patients with wet age-related macular degeneration, the management of patients with uveitis and the management of patients with glaucoma.
- A number of audits assessing compliance of patient management with NICE guidance were underway. For example, 'Compliance to NICE Guidelines of Uveitic Glaucoma Patients Follow up in the Uveitis Clinic'.
- Protocols based on current guidance from the Royal College of Ophthalmologists were in use within the medical imaging department. Individuals within the department had been asked to be involved in the development of new protocols for the royal college.
- Where audit results indicated that management was not fully adhering to best practice guidance, recommendations were made to improve compliance and local protocols were reviewed.
- Staff audited new services and management plans that were implemented in the outpatients services to assess effectiveness. For example, a group of doctors were reviewing the impact of toric intra-ocular lenses in irregular astigmatism.

Nutrition and hydration

- Water coolers and cups were available in most clinic waiting areas. Hot drinks were available from the coffee shop located in the ground floor of the hospital or from machines in the lower ground floor. Staff told us the hot drinks machine frequently broke and the senior staff were trying to instigate a mobile hot drink round from the hospital coffee shop.
- The Friends of Moorfields volunteers ran a refreshment trolley offering a selection of cold snacks for sale. We saw this service doing the rounds of the outpatient clinics during our inspection. Additionally, vending machines selling snacks and cold drinks were available in some clinic waiting areas.
- Senior staff told us sandwiches could be accessed for patients from the coffee shop within the hospital. Both senior and junior members of staff were unclear about which patients were eligible for free sandwiches.

Patient outcomes

- Patients had access to new and innovative treatments through participation in research studies. At the time of our inspection there were a significant number of studies underway, including: six adnexal, nine age related macular degeneration, three cataract, nine corneal external disease, three diabetic retinopathy, eight glaucoma, 14 inherited retinal disease, 16 medical retinal, 6 neuro ophthalmology, five uveitis and three vitreoretinal studies.
- An outcome study measuring patient outcomes following intravitreal Aflibercept therapy showed a significant proportion of patients achieved "driving vision" after three treatments. This was in line with results from research studies in this area.
- There were 3 cases of endophthalmitis at City Road following 15,349 intravitreal injections for patients in 2014/15. This indicated patients receiving intravitreal injections in outpatients at Moorfields Eye Hospital achieved better outcomes than the research studies suggested.
- Almost all patients (98%) who received suturelysis to relieve intraocular pressure in outpatients had a successful procedure. Three patients experienced minor post-procedure complications, whereas the remaining 49 patients had no complications.
- Outcomes for patients receiving treatment for medical retinal conditions were better than all four of the identified standards, including visial stability and visual improvements after injections.
- Of the patients who attended outpatients across the trust between April 2015 and March 2016, 12% were discharged from the service, 75% were given a follow up appointment and 13% had 'unoutcomed appointments'. This statistic included patients who did not attend their appointments.

Competent staff

Nursing Staff:

- The nurse in charge of the clinic they worked in inducted new starters to the clinic areas. Staff were able to shadow colleagues for a flexible period of time before working independently. Specific competency documents were available for different areas of the

outpatients service. Staff had to complete a range of basic competencies, such as infection prevention and control, before moving on to more complicated, role specific competencies. Staff were only expected to work independently on tasks they had been signed off as 'competent' for.

- Four practice nurse educators supported the development of new staff working within outpatients, as well as the ongoing needs of established staff.
- Extended roles were available for nursing staff working in several specialties throughout outpatients. For example some nursing staff were able to perform treatment injections. Staff attended a training day which included sessions run by specialist consultants. There was also a skills laboratory session. Consultants mentored the trainee nurse injectors for their first 50 injections, after which the mentorship would pass on to a fellow for the next 50. The mentor could sign off the nurse injector once they had completed 100 injections and the mentors were happy with nurse's competence. A Patient Group Direction (PGD) was in place for this service.
- Health care assistants and clinic technicians also completed basic care competencies and were supported to complete a care certificate.
- New radiographers received an induction to their working area from the Superintendent Radiographer. They worked under supervision until specific competencies had been signed off when they could then work independently.
- Radiographers attended weekly multidisciplinary team meetings where they received practical training in image interpretation. Staff anonymised and stored example images in their local computer drive for future training sessions.
- Staff in medical imaging were trained to be competent in all imaging modalities within the department. Staff were rotated across the different methods but also given opportunities to develop expertise in certain modalities. Staff in medical imaging attended a weekly training session to develop their knowledge and skills.
- Staff working at lower bands in outpatients told us access to development opportunities was variable throughout the clinic areas. Staff from various backgrounds felt their developmental needs were not considered and told us their opportunities for promotion were very limited unless they completed a degree. Others told us they were supported to develop additional knowledge and skills, such as being encouraged to complete an administration qualification.
- All grades and divisions of staff were required to attend the generic induction and more than 95.7% of staff throughout the directorate completed this.
- Hospital data showed local inductions had been completed for more than 80% of staff throughout the directorate, including nursing staff, administrative and clerical staff, and allied health professionals.
- Staff completed annual appraisals and were positive about their experiences of this process. The trust identified a target of 80% appraisal completion across all staff groups. Qualified nursing staff (93.2% appraisals completed) and additional clinical services staff (88.9%) met the appraisal target. Administrative and clerical, allied health professionals and additional professional scientific and technical staff did not meet the appraisal completion target (57.6%, 67.8% and 71.2% with completed appraisals respectively).

Medical Staff:

- Doctors, including locums, were required to attend the generic trust induction. This had been completed by 79.5% of permanent medical staff and 90.9% of locum medical staff.
- Medical staff were inducted to their working area by a colleague, following an induction checklist. Hospital data showed local inductions had been completed by 82.7% of medical staff and 90.9% of locum medical staff.
- Medical staff were required to have annual appraisals, and the trust target of 80% appraisal completion was applicable. More than 80% of medical staff had up to date appraisals at the time of our inspection.
- Doctors told us they received regular training within their working weeks. Some training sessions were scheduled but others were delivered ad hoc by consultants in clinics, usually about the management of certain conditions triggered by a patient case study. Doctors told us the training they received was good quality and well delivered.

Outpatients and diagnostic imaging

- Staff working with radioactive medicinal products had to be licenced by the national 'Administration of Radioactive Substances Advisory Committee' (ARSAC). Staff licences were overseen by the trust radiation protection advisory committee.

Multidisciplinary working

- Weekly multidisciplinary meetings (MDM) were held for different specialities, for example neuro ophthalmology and ocular oncology. The lid/orbital oncology MDM was held every two weeks in conjunction with a team from another trust via video link. Meetings were held to discuss specific patient cases and were attended by consultants, radiologists, junior doctors, radiographers and ophthalmologists.
- Staff told us they liaised with specialist eye services internationally to discuss complex cases and access expertise from around the world when necessary.
- Staff in clinics worked closely together and liaised to ensure optimal management of patients. For example patients were sometimes seen by more than one specialist clinic to ensure their needs were met. Additionally, staff could be sent to imaging and orthoptics departments directly from clinic.
- After each clinic appointment, doctors dictated letters that were typed up and sent to patients' GPs with details of their treatment. Staff estimated that letters took up to one month to reach the GP. Patients also received copies of these letters.

Seven-day services

- Some clinics were available in the evenings from Monday to Friday and also on Saturdays. Increased outpatients activity was documented on the directorate risk register due to limited availability of support staff, such as estates, portering and security. Additional funding for further staffing was under review for the 2016/17 business planning.
- A rapid access clinic for vitreoretinal patients was available seven days per week. A medical retinal emergency clinic was also available however this was provided Monday to Friday. The 2016/17 outpatients business plan identified the expansion of the service to include a fast track programme which would involve a nurse or technician led diagnostic clinic, with results reviewed by a clinician with 48 hours.
- Diagnostic imaging and other support services had limited opening hours in comparison with some outpatient clinics, which meant patients attending clinics outside of these times could not access all services in one visit.

Access to information

- All referrals to the outpatients departments were paper-based. There was no system available to receive referrals electronically and no method to monitor or audit referrals once received. Patient referrals could therefore be lost or delayed without staff realising. This was recorded on the directorate risk register.
- X-rays and CT scans were interpreted and reported by radiologists within one month of the investigation. The reports were available to staff electronically when completed.
- One nurse we spoke with had been working as a Bank member of staff for five weeks yet did not have access to the hospital computer system. The nurse told us access to certain information was limited because of this and had to rely on colleagues help access information which was stored online.

Consent, Mental Capacity Act and DoLS

- Permanent and locum medical staff were required to complete training on the Mental Capacity Act 2005 and training uptake target of just 30% was identified. Hospital data showed this target was met for permanent and locum staff, as 51.6% and 54.5% had completed this training.
- Staff throughout outpatients and diagnostic imaging understood the importance of patients giving consent prior to any interventions or assessments. We observed staff obtaining verbal consent from patients prior to assessments.
- We saw that consent forms were used appropriately in outpatients prior to procedures. However in the botox clinic, consent was not fully documented and was not documented at all on one record where the patient had received a botox injection.

Outpatients and diagnostic imaging

- Staff were clear that a mental capacity assessment was required if there was doubt about a patient' capacity to make decisions. Medical staff described putting steps in place to support patients to make their own decisions, in line with the Mental Capacity Act.
- Some staff were clear that best interests decisions could be made by medical staff if it was determined that a patient lacked consent, although others incorrectly told us relatives could consent on behalf of the patient.
- Senior staff were aware of Deprivation of Liberty Safeguards (DoLS) although told us this was "never used" in an outpatients settings.

Are outpatient and diagnostic imaging services caring?

Good

Staff working in the outpatients and diagnostic services were caring.

- Results from patient feedback such as the Friends and Family Test and Patient-led Assessments of the Care Environment indicated patients were satisfied with the care they received.
- Most patients were positive about their interactions with staff and the care they received within the department. They told us they were treated with dignity and respect.
- Staff introduced themselves and their role within the clinic to ensure patients understood who they were speaking to. They apologised for clinic delays when greeting patients.
- Patients understood investigation findings and treatment options as staff gave clear explanations and offered patients and their relatives opportunities to ask questions. Patients told us they were involved in making decisions about their care.
- Staff provided emotional support when dealing with sensitive information and referred patients to nurse counsellors or external support organisations where appropriate.

However:

- Not all interactions with staff were positive, for example one patient described being "chastised" by a member of staff on a clinic reception desk.
- We observed some occasions where staff were not thoughtful about their interaction with patients.

Compassionate care

- Results from the Friends and Family Test between December 2015 and February 2016 showed that 96-97% of patients would recommend the care they received in the outpatients and diagnostic imaging department at the hospital. This was better than the national average.
- Results from the 2015 'Patient-led Assessments of the Care Environment' (PLACE) showed the outpatient department scored better than the national average in four out of four domains (cleanliness, privacy, dignity and wellbeing, condition, appearance and maintenance, and dementia).
- Patients were complimentary about their interactions with staff and one patient told us that "staff [were] the strength of this hospital". They told us staff were interested in them as individuals and made an effort to put them at ease during their visit to the hospital. Patients told us they were treated with dignity and respect.
- Most feedback about clinic reception staff was positive and patients told us the staff were friendly and helpful. However, one patient described being "chastised" by a member of reception staff for not having details of his NHS number immediately available and we observed a member of reception staff answer a telephone despite being mid conversation with a patient at the desk. The staff member did not acknowledge or apologise for the interruption to their conversation.
- Patients were complimentary about the care they received from outpatients clinical staff. They told us that they "were in safe hands" and received "the best care you can imagine". Several patients described the care as "worth waiting for".
- Staff were aware that many patients had had significant waits before being seen by medical staff and most provided a suitable apology to the patient when they

were called through to be seen. However in clinic 4 we observed one doctor apologise to a patient in the waiting room for the delay by saying "...sorry for the long wait, I got stuck with a wheelchair patient".

- It was difficult for patients to speak to staff confidentially due to the open nature of the clinic reception desks and the treatment areas. Staff told us patients could request to speak to staff in private rooms but it was unclear how patients were expected to know these were available.

Understanding and involvement of patients and those close to them

- Patients told us clinicians within outpatients always spent time explaining their assessment findings and possible treatment options. Patients did not feel rushed during their face-to-face time with outpatients staff. Staff offered opportunities for patients to ask questions and clarify any information they were unsure about.
- We observed several occasions where staff involved patients in their care and ensured they understood what was happening. For example, we observed a nurse perform a topography scan in clinic 4. The nurse clearly explained the purpose of the scan to the patient and explained the scan procedure. The nurse showed the patient the scan images when completed.
- Patients felt involved and supported in making decisions about their care. Patients told us they were offered different treatment options where available and that staff considered what was best for them as individuals when planning their care.
- Patients and their relatives were clear about their treatment plans and knew when to schedule follow up appointments. Patients also knew how to access help in between clinic appointments if needed.
- We observed most staff introduce themselves and their role to patients when greeting them and staff offered help where needed. We saw staff guiding visually impaired patients and checking the patient was happy with the guidance they were providing.
- Where consultants were not present in clinic, this was highlighted on the clinic boards in the waiting areas.

Emotional support

- Staff delivered results from investigations and assessments in a sensitive and thoughtful. Staff were mindful that investigations indicating deterioration of a patient's eye condition could be upsetting and took care to explain the findings carefully. Patients told us staff were supportive when they received bad news about their sight.
- Ophthalmic nurse counsellors were available to provide support to patients. Any member of staff could refer patients to the counselling service and patients were usually seen for between six and twelve sessions. Patients told us this service was "invaluable" and "should be offered to everyone".
- Staff were aware of external organisations, such as charities, who could provide additional support and assistance to visually impaired patients. We saw staff offering patients contact details for these services.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The responsiveness of the outpatients and diagnostic imaging service was inadequate because the service did not always meet people's needs;

- Clinics were frequently overbooked and finished late. Patients consequently had a long waiting time in clinics and the hospital did not have a system in place to keep patients informed about the waiting time and did not monitor this performance data.
- Some queues at clinic reception desks were long and we observed some patients waited up to ten minutes to check in for their appointment.
- Staff working in the outpatient clinics told us there was no computerised flagging system to highlight patients with specific needs, such as those living with dementia or patients with a learning disability. The trust advised us that the electronic patient record system and the appointment booking system could be used for this purpose, however we did not see this in use during our inspection.
- Patients commented that documentation was in small font, including letters from the hospital and the Friends and Family Test feedback cards. One patient

commented that they had asked for letters in a large font but this had not happened. Some patients also commented that signage to some areas of outpatients was not clear, for example to clinic 11.

- Availability of seating in waiting areas was not sufficient at busy times, despite staff providing additional seating when needed, and we observed patients and their relatives standing because of this.
- We observed many occasions when clinic staff entered patient clinical areas to access paperwork or equipment during consultations which was distracting for both patients and staff.

However:

- Patients could easily access care in the outpatient clinics via a GP referral or directly from the hospital emergency department. The outpatients service was meeting the 18 week referral to treatment time target.
- Access to diagnostic imaging was on a walk in basis and patients were almost always seen on the same day, with short waiting times.
- Some planning to meet individual needs was evident. For example an orthoptic clinic for transitioning patients with a learning disability and access to evening clinics in outpatients.
- The service responded appropriately to complaints and only one complaint had been forwarded to the Parliamentary and Health Service Ombudsman.

Service planning and delivery to meet the needs of local people

- Clinics and imaging services were sign posted from the main entrance to the hospital and our inspection team were able to locate most departments and corresponding reception desks. Volunteers were located at the hospital entrance to provide directions or assistance to patients who needed help finding the right department, however we observed that volunteers were not always available.
- There were two entrances to clinic 11 and the location was not clearly signed from one of the lifts. Additionally, from one entrance it was not obvious where the clinic reception desk was located. Some patients also commented that signage to some areas of outpatients was not clear, including to clinic 11. The Trust advised that they were in the process of upgrading signage at the City Road outpatients site, which had been developed in consultation with the Royal National Institute of Blind People (RNIB) and the Dementia and Learning Disabilities workgroup. The site also passed its PLACE assessment which assesses signage.
- Some clinics were held during evenings (Monday to Thursday) and on Saturdays to address busy caseloads and to provide patients choice when booking appointments.
- Patients were able to leave the clinic waiting areas to get refreshments or fresh air but were advised they should inform the clinic reception staff before leaving so they did not miss their appointment slot. Two clinics were trialling a buzzer system which would alert patients who had left the department when the team was ready to see them.
- Waiting areas were large with lots of seating, however became particularly busy in the afternoons. We observed some patients and their relatives standing in waiting areas as there weren't enough seats available. Staff were aware of this issue and 'floor walkers' provided additional portable seats when possible.
- Television information screens were available in clinic waiting areas. Screens showed various information including staffing data, the number of patients in clinic and the estimated total visit time in clinic. Some text on the information screens was small and difficult to read from the patient waiting area seats.
- Patients could access free wifi in the waiting areas. Additionally we observed some magazines were available in the clinic waiting areas however these were stored in wall mounted magazine racks and were not obviously located.
- Patient toilets were available throughout the clinic areas and immediately next to some waiting areas. In clinic 11, patient toilets were available behind the reception area. Access to these toilets would be difficult for patients using mobility aids, like a walking frame or a wheelchair, as there was only a very slim gap between the waiting area chairs and adjacent wall, however there was a disabled toilet nearby.
- Patients were seen in open bays within clinic areas, which is accepted practice for ophthalmology

outpatient clinics, however in some clinics we observed this resulted in a lot of noise and it was difficult to hear what was being said by both patients and staff. This could prove a challenging environment for the team to effectively review patients with a hearing difficulty, confusion or a learning disability.

- In several clinics when patients were having their initial consultation with the clinic nurse or technician, we noted that reception staff brought clinic notes into the consultation bay and doctors came into the bay to pick up the notes for their next patient. This was distracting for patients being assessed by the nurse or technician.
- Private rooms were available within clinic areas and staff told us these rooms would be used if a sensitive conversation with a patient was necessary, for example if the team were breaking bad news about a patient's diagnosis.
- Patients requiring an MRI scan were referred to a local hospital where a service level agreement was in place for this to be completed. The Trust achieved 100% of all MRI scans undertaken within prescribed timescales, as set out in the national targets (2015-16) of; urgent scans in 0-2 weeks, semi-urgent in 2-4 weeks and 4-6 weeks for routine scans. The Trust also has good performance against National Diagnostic Targets for CT scanning, with 100% of CT scans being performed within the 6 week target. 80% are performed the same day and the average wait for those not done on the same day was 1.16 weeks.
- A patient changing area was available within radiography so patients could change into a hospital gown prior to their scan if required. The changing area had a direct door into the imaging room so patients did not have to walk in a public area in their hospital gown.

Meeting people's individual needs

- Stickers on the cover of medical notes highlighted patients with specific needs. For example, patients who needed physical assistance or guiding had a 'helping hand' sticker on their notes. Staff working in clinics told us there was no electronic system to highlight specific needs of these patients when they checked into clinic (although patients who came to clinic via patient transfer were highlighted) and it was unclear how staff would identify a patient's needs if their permanent medical notes were not available.
- Information provided by the trust indicated that there was an electronic flagging system in place however we did not see this in use during our inspection and staff were unaware of the system. The hospital also advised that the clinic nurses were notified via email in advance of patients who have complex needs or are vulnerable, so that special arrangements could be made in advance to see them in a ward setting.
- A 'Welcome to clinic' leaflet was available at the reception of some clinics, providing information about how the clinic was organised. On the back of the leaflet patients were requested to "let the nurse or doctor know if you have dementia or a learning disability" which was not a reliable or appropriate system for highlighting this individual need.
- Most patients told us staff provided suitable support for visually impaired patients, however we observed some occasions when staff did not provide appropriate support to meet patient needs. For example we saw a member of reception staff directing a visually impaired patient to a chair in the waiting area by shouting directions at the patient from behind the reception desk. One patient told us it was "amazing how many staff [were] insensitive to the needs of visually impaired people".
- Two orthoptic clinics were held each year to support the transition of paediatric patients with a learning disability to adult care. Staff told us these clinics were small and allowed staff to spend additional time with patient to improve their experience.
- Outpatients staff were not always responsive to the needs of patients. For example we observed a patient booking appointments for two clinics with a member of reception staff. The staff member offered the appointments two days apart, despite the patient commenting they had a long journey to get to the hospital and asking if they could they have the appointments on the same day. The clinics the patient needed to attend were available on the same day but the receptionist did not recognise this when booking the patient's appointments. The trust advised us that there were some occasions when it would not be appropriate for a patient to attend two clinics on one day, however this was not explained to the patient during the interaction we observed.

Outpatients and diagnostic imaging

- We observed the entrance doors to clinic 11 were closed during our inspection. We were concerned that patients with mobility difficulties or those in wheelchairs would not be able to easily access the clinic, particularly as there was no way to attract the attention of staff in the clinic to help. We raised this concern with clinic staff who told us the doors had automatically closed during a fire alarm test and were usually open. When we returned to the clinic later the doors were open, however we remained concerned that clinic staff had not opened them earlier and that they would have remained closed if we had not raised our concerns. During our unannounced inspection, we saw one set of doors to clinic 11 remained closed.
- Patients with mobility difficulties could use hospital transport to attend their clinic appointments. Some patients travelling on public transport could claim the cost of their transport back from the hospital.
- Bariatric chairs were available within clinic waiting areas and in clinics. The chairs in waiting areas were interspersed with other waiting chairs and could be moved where needed. There were 15 specifically designed bariatric chairs on the ground and lower ground floor clinic waiting areas. The chairs in clinic treatment areas can hold a patient weighing up to 150kg and have retractable arms, allowing full access for bariatric patients.
- A number of leaflets were available throughout the outpatients waiting areas. Leaflets provided information about specific conditions like glaucoma, different treatments and support services. All leaflets we saw available in waiting areas were written in English. Senior staff told us leaflets in three other languages (Turkish, Punjabi and Guajarati) were available from the information hub at the hospital entrance and that staff could also print leaflets directly from the hospital intranet. Large print leaflets were also available and some information was provided in braille.
- Some patients commented that documentation from the hospital was in small font size. We were advised by the Trust that all standard patient letters, information leaflets and other documentation were in size 14 font (as per RNIB guidelines)but patients can request communications in larger size font or other formats, such as email or braille. One patient told us they had requested large print letters but this had not happened.
- Patients were asked to complete the Friends and Family Test by clinic reception staff after their appointments. We observed some patients struggling to complete the form and one patient commented to staff that the text was too small.
- The Friends of Moorfields volunteers ran a refreshment trolley offering a selection of cold snacks for sale. We saw this service doing the rounds of the outpatient clinics during our inspection. Additionally, vending machines selling snacks and cold drinks were available in some clinic waiting areas.
- Senior staff told us sandwiches could be accessed for patients from the coffee shop within the hospital. Both senior and junior members of staff were unclear about which patients were eligible for free sandwiches.

Access and flow

- Patients accessed the outpatients service via a referral from their GP or through the Moorfields emergency department. Patients were booked for their initial appointment in the relevant clinic by the central bookings office.
- Referral scrutiny took place every 24 hours by a member of the relevant clinical team. Where it was unclear which specialist clinic was required, patients were booked in to a general clinic held in Clinic 5 for assessment and specialist streaming. The next available appointment was allocated to the patient and a letter was sent to them identifying the date and time of their appointment. Patients received a text message appointment reminder when they had a mobile phone number registered with the hospital.
- The hospital identified an 11-week target for patients to have their first outpatient appointment after referral. From April 2015 to March 2016, an average of 50.8% of patients waited for more than 11 weeks for their first appointment.
- The hospital identified a two-week target for 93% of urgent oncology patients to have their first outpatient appointment after referral. NHS England requested that Moorfields took over this service due to concerns over pathway and demands. When the service was taken

over from another provider in July 2015, the 2-week target was achieved in 86% of patients. After pathway modification, the service achieved the 2-week target in 100% of cases.

- The specialist services provided by the outpatients department exceeded the 92% 18-week referral to treatment time target for non-admitted patients between April 2015 and March 2016, achieving an above target rate of 94.7%.
- Non-urgent patients were able to call and electively change their allocated outpatient appointment once. They were not able to change their appointment date a further time and had to be re-referred to the service by their GP to continue accessing care if they could not make their appointment. This was completed in accordance with the CCG/Trust agreed access policy and was based on National guidance.
- Some patients told us it was difficult to get through to the central bookings office and that they had to wait for a long time before their calls were answered. Information from the hospital from April to December 2015 showed between 92-98% of calls were answered in two minutes or less. Between 2-5% of calls were abandoned by the caller.
- If patients developed complications in between their clinic appointments, they could contact their consultant's secretary and try to book into an available clinic. If this was not available, the secretary advised patients to attend the A&E department for assistance.
- Clinics had a maximum number of patients identified on the clinic schedule, however we saw evidence of clinics being over booked. For example during our unannounced inspection on 20 May, there were 55 patients booked into the clinic 2 glaucoma morning session which should have had a maximum of 45 patients. Clinic 3 glaucoma was also overbooked with 52 patients instead of the maximum 45. Staff told us they overbooked patients into clinics as they knew a number of patients would not attend and so the clinic could cope with the extra patients.
- Between February and April 2016, 2320 patients (14.5% of new patients) did not attend their initial outpatients appointment without cancelling or informing the hospital they could not attend. This was worse than the hospital's 8% target, however was in line with other ophthalmology services in London. In the same period, 7150 patients (10.35% of follow up patients) did not attend their follow up outpatient appointment without cancelling or informing the hospital they could not attend. This was better than the hospital's 12% target. In order to address the issue of patients failing to attend their appointments, the Trust started to use text message reminders with positive results.
- If new patients do not attend their first appointment they were automatically re-booked. When non-urgent patients did not attend their outpatient appointment, senior clinical staff (consultant/senior fellow) reviewed the referral information to rebook if clinically needed; otherwise they were discharged back to the care of their GP in accordance with the CCG agreed access policy. When clinically indicated, consultants asked their secretary to follow up selected patients with a telephone call to offer the opportunity to rebook.
- Staff told us a number of clinics frequently finished late, for example one morning clinic often ran until 3pm. One staff member told us some consultants would see patients no matter how late they arrived after their appointment time, which caused a delay to other patients. The hospital did not monitor clinic finish times and staff told us nothing was done to address the issue.
- We observed staff checking patients in for their appointments at the clinic reception desks. Some clinic receptions became busy quickly and we saw large queues of up to 11 patients forming to check in. Most patients were checked in quickly, however at busy times patients waited for up to ten minutes before speaking to reception staff.
- Staff told us patients were seen in the order of their appointment time, not by time of arrival although some staff told us patients who used hospital transport services were prioritised in clinics so the flow of transport services was not affected.
- Patient waiting times were not monitored in the outpatient clinics however were identified as a contributory factor for a risk documented on the directorate risk register. Patients told us they were seen quickly by the clinic nurse but then had a long wait, often over an hour, to see the doctor. There were no systems in place to inform patients how long it would

take for them to see a doctor, although signs on the television information screens advised patients they could ask at the clinic reception if they had been waiting for an hour or more.

- Patients told us waiting times were long but that it was worth waiting to be seen because the care they received when they finally were seen was so good. Several patients told us "[we are] used to the long waiting times".
- Total visit times in outpatients were monitored by the hospital and an estimated total visit time was displayed at the reception desk of each clinic. Staff told us this was this was displayed as some new patients did not realise how long their outpatient visit would last for although all new patient letters give an indication of visit duration. We saw two patients complaining to reception staff about how long their visit was taking.
- Patients accessed diagnostic imaging services within the hospital by being referred directly from the outpatients service. A 'walk in' service was available within medical imaging and radiography and most patients were seen on the same day. In radiography, patients were able to make an appointment for their investigations if they preferred.
- Images obtained from x-rays and CT scans were interpreted and reported by radiologists. The reports had to be completed by certain date each month so they could uploaded to an image sharing database by the Superintendent Radiographer.
- Patients were diagnosed quickly after investigations had been completed and no patients waited for more than six weeks for a diagnosis.
- Orthoptics was available to patients referred from the outpatients department. Patients were allocated an 'arrival' time and were seen as soon as possible, with an average waiting time of approximately 20 minutes. From April 2015 to March 2016, 100% of patients were seen within the six-week referral to investigation target period.
- The hospital cancelled 469 clinic elements (10.3%) between February and April 2016. Of these, 353 (7.7%) were cancelled more than six weeks ahead and 116 (2.5%) were cancelled with less than six weeks notice. This was better performance than the Moorfields Eye Hospital outpatient service at St George's Hospital.

Learning from complaints and concerns

- Between January and December 2015 there were 102 complaints made about the outpatients department. Themes from complaints included staff attitude, organisational issues in the department and concerns about clinical care.
- One complaint was escalated to the Parliamentary and Health Service Ombudsman (PHSO). Complaints are escalated to the PHSO when patients are not satisfied with the complaint response they receive from hospitals. The PHSO declined to investigate the complaint that was taken to them, as they were satisfied with the hospital's investigation and response.
- We reviewed examples of complaint responses that provided patients with apologies where appropriate and full details of the investigation into the complaint that took place.
- We saw evidence of actions in response to patient complaints. For example senior staff introduced hearing loop systems to outpatient clinics after a patient complained they were not available.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

The leadership of the outpatients and diagnostic imaging services required improvement. We found:

- Key issues relating to flow within the outpatient clinics, such as patient waiting times and clinics overrunning, were not formally monitored by the leadership team and therefore the benefit of any service changes could not be effectively assessed.
- Senior staff identified issues with the current environment and identified a newly built hospital as the

key to addressing this; it was unclear what short/ medium term plans were in place to mitigate the issues in the short term, although we were told by the Trust that a number of options were being considered.

- Risks and contributing factors were not always fully mitigated. For example, 'floor walkers' were introduced to ensure patient well-being in the waiting areas however staff told us floor walkers were only sometimes used.
- Staff feedback regarding the leadership team was variable. Some staff told us they lacked confidence in the team because of issues in outpatients not being addressed (for example clinic overrunning). Some staff also told us they did not know who the leadership team were or that they were not visible in the department.

However:

- There were suitable governance arrangements in place, which included twice-yearly feedback to all directorate staff.
- Risk registers matched the concerns we identified during our inspection and we saw evidence that a suitable scoring and monitoring system was in use.
- There were regular audits and involvement in research, as well as some evidence of innovation.
- We saw examples of patient engagement in service development.

Vision and strategy for this service

- The outpatients 2016/17 business plan outlined a vision for service development, which focused on improving quality and safety of services provided. Staff within outpatients and imaging services were aware of some aspects of this vision, such as the development of the virtual glaucoma clinic however most staff identified a new hospital building as the overarching vision.
- Senior staff consistently identified the outpatients departments physical environment as being unsuitable for its current use. Staff throughout outpatients identified a newly built hospital on a different site as the solution to these difficulties. However, they were aware that this type of development would take a long time to come into fruition. Other than modifying the glaucoma service, there were no clear plans to identify how the environment could be managed in the short/medium term to address its current unsuitability. The Trust also had a Space Committee which has been considering moving individuals and services throughout the campus to ensure that patient facing areas are maximised.

Governance, risk management and quality measurement

- The radiation protection advisory committee met on a six monthly basis and was formed by a multidisciplinary group of staff, including matrons, consultants and radiographers. The committee discussed any relevant service development changes and incidents that had occurred.
- Quarterly clinical governance half day updates were held for clinical and administrative staff. Minutes showed staff were given updates about complaints, clinical incidents and performance data. We reviewed attendance lists from the last two administrative staff governance updates that showed attendance from 63 and 43 staff members respectively. The Trust advised that other administrative staff would have attended their specific service clinical governance sessions.
- A clinical improvement group met on a monthly basis to discuss and address performance issues, for example in response to patient feedback about telephone etiquette of staff. The group put suitable steps in place and monitored patient feedback to improve the issues identified.
- A transformation group met monthly to discuss and implement plans for service development. The group was responsible for completing a time and motion study into the clinic movements of glaucoma patients that was completed in 2015. This study demonstrated areas where patients spent the most time during their outpatient visit and the location of some services were rationalised to improve patient flow. The group were working on developing a 'virtual glaucoma clinic' to improve patient care and experience.
- Outpatients management staff maintained clinic specific risk registers as well as a broader directorate risk register. The risks documented on both sets of registers reflected our inspection findings. The risk registers showed that suitable risk scoring was completed and actions to mitigate risks were delegated to specific members of staff.

- Risks and contributory factors were not always suitably mitigated. One issue documented on the directorate risk register was "Risk of adverse event occurring in clinic waiting area due to frail, elderly patients due to cardiac event or hypoglycaemia". Prolonged waiting times were documented as a contributory factor to this on the directorate risk register, however waiting times were not being recorded. This meant it was not possible for the leadership team to fully monitor this issue. Overcrowding of waiting areas was also documented as a contributory factor, however we did not see evidence that patient flow was being fully addressed to improve this.
- Senior staff introduced 'floorwalkers' who were technicians responsible for overseeing patient welfare in the waiting areas. Clinic staff told us floorwalkers were only used when staffing allowed and we observed limited availability of these staff members during our inspection.
- We saw evidence of an audit programme detailing a significant number of clinical audits that were undertaken by outpatients medical staff and allied health professionals. A number of audits were ongoing at the time of our inspection. For example, an audit assessing compliance with local protocols for scheduling injections for age-related macular degeneration patients and an audit reviewing compliance of the glaucoma service against NICE guidelines. We did not see evidence of audit activity carried out by nursing staff.

Leadership of service

- Experienced clinicians and management staff led the outpatients and diagnostic imaging services. The leadership team were supported in their roles by the trust management.
- We observed members of the management team in outpatients clinics and they knew many staff members by name. Most staff told us they felt valued by the directorate leadership team and that their work was appreciated. However some staff, including two consultants, did not know who the outpatients and trust management teams were and told us they had never met them. They told us they received emails and were expected to act upon the information contained despite not knowing who the management staff were who had sent the email because they had never met them.
- Confidence in the outpatients leadership team was variable amongst staff in the department. They cited issues with late running clinics and lack of monitoring or action from the management team to address problems as an example for their lack of confidence in the team. Other staff members were positive about outpatients management staff.

Culture within the service

- Staff were complimentary about managers within the outpatients and imaging departments. They told us their managers provided support about workplace issues and some staff identified their line managers as being supportive about personal problems too.
- Staff felt valued in their roles and told us their expertise in certain areas was acknowledged and used. They told us the management teams made good use of their individual skills and tried to ensure they had opportunities to use their knowledge. Most staff told us they were supported to developed their skills and progress. For example, one clerical staff member had been supported to train as a medical photographer.
- We saw staff interacted to support one another during patient visits. For example junior doctors sought out the expertise of their more senior colleagues when unsure about investigation findings or treatment options. Staff were keen to share their knowledge and support each other on their day to day work.
- Up until March 2016, orthoptics staff had been expected to attend a departmental meeting at 5pm which was after their official finish time. This was subsequently changed to morning and lunchtime meetings.
- During our inspection, staff did not raise any concerns about bullying or harassment within the outpatients or imaging departments. However we noted results from the 2015 NHS Staff Survey showed 25% of staff had experienced this from other members of staff (in comparison with the 27% average). More staff in the

outpatient directorate than the trust average also reported workplace discrimination (19% in comparison with 14%) and physical violence from other staff was the same as the average (2%).

- Sickness rates were 0.25% for medical staff, allied health professionals and administrative and clerical staff between April 2015 and March 2016. Additional professional scientific staff , registered nurses and additional clinical services staff had an average sickness rate between 3-5% for the same period. Sickness rates were the worst for estates and ancillary staff who had an average sickness of 7.66%.
- The 2015 NHS Staff Survey indicated 54% of outpatients directorate staff reported feeling pressured to attend work despite feeling unwell, which was better than the trust average (56%). Reports of work related stress were slightly worse than the trust average (30% compared with 28%).

Public and staff engagement

- A patient focus group was held to establish patient opinions relating to the development of a new diabetes passport. An ophthalmologist and a group of clinical fellows led this group.
- Senior staff organised sessions called “In Your Shoes” which involved staff members hearing direct patient feedback of their experiences at the hospital and offered an opportunity for staff to ask questions about how they can best support patient needs. A range of staff grades from outpatients attended these sessions.
- In January 2015 a patient survey was completed to establish patient opinions about the clinics held on Saturday and extending the outpatients service to include Sunday clinics. Findings showed most patients felt the service they received on a Saturday was the same or better than the outpatients service on weekdays. Results also showed 59.2% of patients who responded to the questionnaire would be happy to attend a Sunday clinic. At the time of our inspection, no outpatients clinics were scheduled to run on Sundays.
- A patient survey was completed in 2015 to establish patient views about the uveitis clinic. Results showed positive opinions about the approach of staff and the organisation of the clinic. Most patients did not identify clinic waiting times as a problem.
- There was evidence of staff involvement in service developments. The importance of this was recognised as part of the 'Moorfields Way' where staff were engaged to ask how their work could be better. The new Service Improvement and Sustainability programme recognises that staff are required to be involved in service improvements directly.
- Some staff felt they could influence changes made at Moorfields Eye Hospital; for example one nurse told us they had been involved in planning a new outpatients area on the third floor of the City Road site to ensure it met the needs of staff and patients. This reflected results from the 2015 NHS Staff Survey which showed that 67% of staff working within the outpatients directorate felt able to contribute to improvements at work. However this was lower than the 73% trust average.

Innovation, improvement and sustainability

- Moorfields outpatients department was heavily involved in developing evidence based practice and in trialling new treatment techniques. At the time of our inspection there were a significant number of studies underway, including: six adnexal, nine age related macular degeneration, three cataract, nine corneal external disease, three diabetic retinopathy, eight glaucoma, 14 inherited retinal disease, 16 medical retinal, 6 neuro ophthalmology, five uveitis and three vitreoretinal studies.
- There was evidence of innovative practice for example the introduction of a nurse delivered intra-vitreal service.
- The outpatients 2016/17 business plan identified a number of costs savings. As an example, staff described changing to single use equipment in the glaucoma service rather than continuing with multiple use items, as it was thought this was a better option for patient safety. They explained that this was a more expensive choice however patient needs were more important.

Outstanding practice and areas for improvement

Outstanding practice

- Staff's sensitivity to the needs of children, young people and their families was outstanding.
- Play staff were able to engage with children on a one to one basis to provide age appropriate activities and distraction when they became anxious. This input was available in all areas of the RDCEC including A&E and outpatients clinics.
- The written information provided was of very high quality and an internet resource had been designed for children and young people, giving information about eye conditions. It was divided into three different age groups and also had an animated eye, a virtual children's eye hospital and other interactive features suitable for children.

Areas for improvement

Action the hospital MUST take to improve

- Ensure the World Health Organisation (WHO) surgical safety checklist is consistently implemented for all surgical procedures including the five steps of team brief, sign in, time out, sign out, and debriefing.
- Ensure adequate audit and monitoring systems are in place to monitor performance and compliance of the five steps to safer surgery safer surgery checklist to guide improvement.
- Ensure that the quality and safety of the outpatients service are fully monitored, including patient waiting times and clinic finish times.
- Ensure that risks relating to patient waiting times are fully mitigated.
- Ensure that patient records are fully and legibly completed, including staff signatures, record entry dates and documentation errors correctly marked

Action the hospital SHOULD take to improve

- Look for ways to improve patient privacy in the OPD, accident and emergency department and day case wards.
- Consider implementing the business plan for an electronic record system and scanning of casualty cards. This will free up space within the administration office and eliminate the risk of trips.
- Repair the ventilation system within the emergency department.
- Improve the waiting area for children and young people in the main accident and emergency department.
- Ensure all staff complete all aspects of mandatory training.
- Ensure all staff are aware of the incident reporting process.
- Ensure all staff have knowledge and awareness of the duty of candour principles.
- Ensure staff are aware of the most up to date laser guidelines
- Ensure staff have the correct training and implement formalised systems to monitor and record staff training information for paediatrics within the theatre department.
- Improve the availability and storage of medical records.
- Work to reduce the number of operations cancelled due to theatre cancellations.
- Develop a strategy for services for children and young people and consider how reporting about plans, priorities and the quality and safety of the service could be improved.
- Improve the uptake of appraisals and ensure all staff are aware of their responsibilities in relation to the Mental Capacity Act 2005.
- Consider how documentary information and signage could be improved for people with visual impairment
- Ensure all staff are aware of the electronic flagging system for vulnerable patients, such as those living with dementia or a learning disability in the outpatients department.
- Ensure that the environment of the outpatient department is routinely monitored and appropriate actions are taken to ensure patient safety, comfort and welfare.

Outstanding practice and areas for improvement

- Ensure emergency buzzers are available in radiology.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014: Safe care and treatment. 12 (1) (2) (a) (b) **Systems were not in place and not fully embedded to address safety issues within the surgical setting through the use of the world health organisation (WHO) five steps to safer surgery checklist.** The World Health Organisation (WHO) surgical safety checklist was not always appropriately and fully completed in theatres. The safer surgery checklist documentation was not always fully completed. Audit and monitoring data to assess compliance and performance quality of the checklist was not regularly collected. The hospital must take action to: • Ensure the safer surgery checklist is consistently implemented for all surgical procedures including the five steps of team brief, sign in, time out, sign out, and debriefing. Reg 12 (2) (a) (b) • Ensure adequate audit and monitoring systems are in place to monitor performance and compliance of the five steps to safer surgery safer surgery checklist to guide improvement. Reg 12 (2) (a) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Systems and processes were not in place to fully assess, monitor and improve the quality and safety of the outpatients services provided.

Risks relating to the health, safety and welfare of service users were not fully monitored or mitigated in the outpatient services.

Accurate, complete and contemporaneous records, including the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided, were not maintained in the outpatients services.

The hospital must take action to:

- ensure that the quality and safety of the outpatients services are fully monitored, including patient waiting times and clinic finish times. Reg 17(2)(a)
- ensure that risks relating to patient waiting times are fully mitigated. Reg 17(2)(b)
- ensure that patient records are fully and legibly completed, including staff signatures, record entry dates and documentation errors correctly marked. Reg 17(2)(c)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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