Optegra Yorkshire Eye Hospital

Quality Report

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

Ratings

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

Overall summary

Optegra Yorkshire Eye Hospital is operated by Optegra UK. The hospital provides a range of ophthalmic services to NHS funded and private-fee paying adults only. These include refractive, ocular plastic and retinal diagnostic and surgical services and ophthalmic disease management.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 7 November 2017, along with an unannounced visit to the hospital on 14 November 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

Summary of findings

are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

The main service provided by the hospital was surgery. The hospital also provides outpatient services for adults. We inspected the surgery and outpatients services. The surgery and outpatient services worked closely together with staff working between disciplines. Where our findings on surgery – for example, management arrangements – also apply to outpatient services, we do not repeat the information, but cross-refer to the surgery core service.

We rated this hospital as good overall. This was because: -

- There was a policy for managing and reporting incidents and staff understood how to report incidents.
- There were no never events or serious incidents reported by the hospital during the last 12 months. Incidents were investigated to assist learning and improve care.
- The staffing levels and skills mix was sufficient to meet patients' needs. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. The majority of staff had completed their mandatory training and annual appraisals.
- There had been no safeguarding concerns raised by the services during the past 12 months. Most staff had completed adults and children safeguarding training and were aware of how to identify abuse and report safeguarding concerns.
- Patients received care in visibly clean and appropriately maintained premises. Suitable and well maintained equipment was available to support patients. Resuscitation equipment was available for use in an emergency.
- The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist.
- The services measured patient outcomes through clinical audits. Audit data and patient reported outcomes measures (PROMs) showed the hospital performed in line with national and local standards for lens exchange treatments and cataract surgery.
- Staff sought consent from patients before delivering care and treatment. Staff understood the guidance around 'cooling off' periods and we saw that minimum cooling off periods of at least one week were observed.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.
- Patients and their relatives spoke positively about the care and treatment they received. Patients were kept fully involved in their care and the staff supported them with their emotional needs.
- Feedback from patient surveys showed that patients were positive about the care and treatment they had received.
- The hospital provided a 24 hour helpline for advice to patients outside of normal working hours. Consultants were available during normal working hours to review patients if staff felt medical input was required.
- The initial patient consultations allowed staff to plan the care and treatment in advance so patients did not experience delays in their treatment.
- The average waiting time from referral to treatment was approximately seven weeks for NHS funded patients and approximately eight weeks for private fee paying patients. There were no procedures cancelled or rescheduled between July 2017 and September 2017.

Summary of findings

- The hospital was accessible for patients with mobility issues and wheelchair users. Patient complaints were managed effectively and information about complaints was shared with staff to aid learning.
- There was effective teamwork and clearly visible leadership across the hospital. There was routine public and staff engagement and actions were taken to improve the services.
- The hospital's vision and values had been cascaded and staff had a clear understanding of what these involved.
- There was a clear governance structure in place. Key risks to the services were recorded and managed through the use of a risk register. Audit findings and quality and performance was routinely monitored.

However, we also found the following issues that the service provider needs to improve:

- Patients were informed about off-licence use of cytotoxic medicines as part of the consent process. However, the Mytomicin C consent form referred to an international medicines regulator and not the licensing authority for medicines in the UK.
- The hospital did not routinely submit data to the Private Healthcare Information Network (PHIN) in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- We found some medicines openly stored in cupboards within unlocked consultation rooms in the outpatient's area.
- Outpatient clinic wait times (from arrival to being seen) were not routinely monitored by the service.
- We did not see patient information readily available in different format, such as large print that would be useful for patients with impaired sight.

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

Ellen Armistead

Deputy Chief Inspector of Hospitals (North Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, responsive, caring and well-led.
Outpatients and diagnostic imaging	Good 	Staffing was managed jointly with surgery. We rated this service as good because it was safe, responsive, caring and well-led. We do not rate effective for outpatient and diagnostic services.

Summary of findings

Contents

Good

Optegra Yorkshire Eye Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Optegra Yorkshire Eye Hospital

Optegra Yorkshire Eye Hospital is operated by Optegra UK. The hospital joined the Optegra group of eye hospitals in January 2011. It is a private hospital in Bradford, West Yorkshire. The hospital primarily serves the communities across the West Yorkshire area. It also accepts patient referrals from outside this area.

Optegra Eye Hospital Yorkshire provides a comprehensive range of ophthalmic services to adults only. These include refractive, ocular plastic and retinal diagnostic and surgical services and ophthalmic disease management. Specific services cover: -

- Outpatient ophthalmic consultations
- Ophthalmic diagnostics
- Cataract diagnostics and treatment including surgery
- Retinal disease/injury diagnostics and management or treatment including surgery and anti-angiogenic (anti-vegF) injections.
- Corneal disease/injury diagnostics or treatment including surgery
- Glaucoma diagnostics and disease management or treatment including surgery
- Conjunctiva, sclera, eyelid and eyebrow, lacrimal, globe and orbit disease/ injury diagnostics and management or treatment including surgery
- Minor injuries and non-urgent treatments
- Neuro ophthalmology
- Paediatric orthoptics (no longer provided from 1 November 2017)

The hospital provides an ambulatory day care service using local anaesthetics only, for adult patients aged 18 and over. It utilises the service of 23 local consultants who all hold substantive posts with the NHS. The hospital does not provide overnight beds and will not admit patients for treatment who may require an overnight stay.

The hospital has had a registered manager in post since May 2011. The current registered manager was appointed in March 2017 and is also the hospital director for the service.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise in ophthalmic surgery. The inspection team was overseen by Lorraine Bolam, Head of Hospital Inspection.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 7 November 2017, along with an unannounced visit to the hospital on 14 November 2017.

We spoke with a range of staff including theatre staff, nurses, technicians, ophthalmologists, optometrists, theatre coordinator, the outpatients coordinator, the clinical services manager, the registered manager (hospital director), the eye sciences (audit) lead and the governance lead. We reviewed nine sets of patient records (paper and electronic) and spoke with eight patients and the relatives of two patients. We also received 'share your experience' comment cards from eight patients. We observed the care pathway from initial enquiry, pre-consultation, eye examinations, surgical assessment, the surgical procedure and aftercare.

Summary of this inspection

Information about Optegra Yorkshire Eye Hospital

The hospital provides an ambulatory day care service using local anaesthetics only, for adult patients aged 18 and over. It utilises the service of 23 local consultants who all hold substantive posts with the NHS. There were no inpatient stays at the hospital, all patients were treated as 'day cases' and were discharged the same day.

The hospital does not offer surgical treatment to under 18 year olds. The service previously provided orthoptic treatment for children but has ceased providing treatment for patients under 18 years of age since the end of October 2017.

The hospital comprises of two ophthalmic theatres, one pre-operative admission area, one post-operative recovery area, five consulting rooms, four diagnostic rooms and three administration areas. The hospital had suitable arrangements for wheelchair access, including an access ramp, toilet facilities and a lift.

The hospital is registered to provide the following regulated activities:

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

  There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has previously been inspected two times. The most recent inspection took place in September 2013, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (November 2016 to October 2017)

- In the reporting period there were 4,103 surgical day case episodes of care recorded at the hospital; of these approximately 70% were NHS-funded and 30% other funded. Surgical treatments consisted of: -
  - Vitreo-retinal (VR) surgery – 26 patients
  - Age-related macular degeneration (AMD) – 968
  - Cataract surgery – 1926
  - Ocular Plastics – 389 patients
  - Refractive Lens Exchange surgery – 794 patients
- There were 9,617 outpatient total attendances in the reporting period. These
  - Initial appointments (including glaucoma) – 1545 patients
  - Follow up appointments (including glaucoma) – 7223 patients
  - Glaucoma Initial appointments – 107 patients
  - Glaucoma Follow up appointments - 742 patients
- The hospital also provided orthoptic treatment for 77 patients under 18 years of age during the 12 months prior to the inspection.

  23 consultant ophthalmologists worked at the hospital under practising privileges. Optegra Yorkshire Eye Hospital employed nine registered nurses, two optometrists, one orthoptist, five healthcare technicians, 12 patient liaison and administrative staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety:

- No Never events
- No patient deaths
- No serious injuries
- 31 Clinical incidents (low or no harm)
- One incidence of hospital acquired infection (suspected endopthalmitis - inflammation of the interior of the eye)
- 15 formal complaints

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cleaning and domestic services
- Maintenance of medical equipment

Summary of this inspection

- Sterilisation of surgical equipment

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There was a policy for managing and reporting incidents and staff understood how to report incidents.
- There were no never events or serious incidents reported by the hospital during the last 12 months. Incidents were investigated to assist learning and improve care.
- The staffing levels and skills mix was sufficient to meet patients' needs. Most staff had completed mandatory training. Patient records were completed appropriately.
- There had been no safeguarding concerns raised by the services during the past 12 months. Most staff had completed adults and children safeguarding training and were aware of how to identify abuse and report safeguarding concerns.
- Patients received care in visibly clean and appropriately maintained premises. Staff demonstrated good compliance and understanding of infection prevention and control guidelines. There were systems in place for management of sharps and disposal of clinical waste.
- Suitable and well maintained equipment was available to support patients undergoing treatment. Resuscitation equipment was available for use in an emergency.
- The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist.
- Staff were aware of the actions to take in the event of a major incident or a fire. Staff were aware of duty of candour guidelines and understood the principles of being open and honest with patients.

However;

- We found some medicines openly stored in cupboards within unlocked consultation rooms in the outpatients area.
- Patients were informed about off-licence use of cytotoxic medicines as part of the consent process. However, the Mytomicin C consent form referred to an international medicines regulator and not the licensing authority for medicines in the UK.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- The services measured patient outcomes through clinical audits. Audit data showed the hospital performed in line with national and local standards for lens exchange treatments and cataract surgery.
- Findings from hospital-led patient reported outcomes measures (PROMs) the majority of patients had a positive outcome following their care and treatment.
- Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. The majority of staff had completed their annual appraisals.
- Staff sought consent from patients before delivering care and treatment. Staff understood the guidance around 'cooling off' periods and we saw that minimum cooling off periods of at least one week were observed.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.

However;

- The hospital did not routinely submit data to the Private Healthcare Information Network (PHIN) in accordance with legal requirements regulated by the Competition Markets Authority (CMA).

Are services caring?

Good

We rated caring as good because:

- Patients and their relatives spoke positively about the care and treatment they received. They told us they were treated with dignity and compassion and their privacy was respected.
- Patients were kept fully involved in their care and the staff supported them with their emotional needs.
- Feedback from patient surveys showed that patients were positive about the care and treatment they had received.
- The patient experience survey (2016/2017) showed 97% of patients would recommend the hospital to family and friends and 81% 'highly likely' to recommend.

Are services responsive?

Good

We rated responsive as good because:

- Patients attended a clinical assessment prior to being seen by the consultant, where any patients deemed unsuitable for treatment were identified. This included patients requiring high dependency care or those with a body mass index (BMI) above 30.

Summary of this inspection

- The hospital provided a 24 hour helpline for advice to patients outside of normal working hours. Consultants were available during normal working hours to review patients if staff felt medical input was required.
- The initial patient consultations allowed staff to plan the care and treatment in advance so patients did not experience delays in their treatment.
- The average waiting time from referral to treatment was approximately seven weeks for NHS funded patients and eight weeks for private fee paying patients.
- There had been no cancellations for surgery or rescheduled surgery between July 2017 and September 2017.
- The hospital was accessible for patients with mobility issues and wheelchair users. Staff could access interpreter services and there were systems in place to support vulnerable patients.
- Patient complaints were managed effectively and information about complaints was shared with staff to aid learning.

However;

- Outpatient clinic wait times (from arrival to being seen) were not routinely monitored by the service.
- We did not see patient information readily available in different format, such as large print that would be useful for patients with impaired sight.

Are services well-led?

Good

We rated well-led as good because:

- The hospital's vision and values had been cascaded and staff had a clear understanding of what these involved.
- Key risks to the services were recorded and managed through the use of a risk register. Audit findings and quality and performance was routinely monitored.
- There was a clear governance structure in place with routine operations meetings as well as medical advisory committee, clinical service manager and integrated governance steering group meetings.
- There was effective teamwork and clearly visible leadership across the hospital. There was routine public and staff engagement and actions were taken to improve the services.
- There was a patient-focussed culture across the service. The hospital had an action plan (March 2017) to improve issues highlighted in the 2016 staff satisfaction survey in relation to clarity on targets and progress, information technology, job satisfaction, infrastructure, communication between teams and staff shortages.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Are surgery services safe?

Good

The main service provided by this hospital was surgery. Where our findings on out patients and diagnostic imaging, for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated safe as good.

Incidents

- The hospital had a standard operational procedure for managing and reporting incidents, this was an Optegra corporate policy. Incidents were reported via an electronic system to which all staff had access. The staff we spoke with at the time of our inspection knew how to access the system and what incidents they should report.
- The incident policy stated that the hospital was bound by the procedures relating to the 'National Framework for Reporting and Learning from Serious Incidents' and the 'Strategic Executive Information System (STEIS)' as directed by the Department of Health and NHS England and other external reporting requirements.
- The hospital had no serious incidents reported during the last twelve months. The incident log (2017) showed 16 incidents recorded for 'clinical-theatres' and four incidents recorded for 'clinical, post-op'.
- All incidents had been investigated, root cause analyses undertaken and action plans developed with learning outcomes identified. The incidents ranged from equipment and environment issues, lens checking errors and list overbooking to surgical complications.
- There had been no 'never events' reported during the last twelve months. Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations have been implemented by healthcare providers.
- Issues that may affect clinical effectiveness were discussed at the Medical Advisory Committee (MAC) meetings and the clinical governance meetings. Minutes were recorded and shared amongst staff to raise awareness and learning from incidents.
- Safety huddles were conducted daily; important safety issues and incidents were communicated at these meetings to highlight significant concerns and potential safety issues.
- 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.
- Although the hospital had not experienced an incident which fitted the criteria for duty of candour processes, we found that managers in the hospital were aware of requirements and had received training. We found that although other staff were less familiar with the legislative requirements, they were aware of the principles of being open and honest with patients.

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

- A clinical quality report was produced quarterly and summarised performance in key areas, for example;

unplanned re-admissions, transfers to other services and infection control. This was shared within the hospital to provide an oversight of results and achievements.
- The report was used to monitor improvements in performance over time and to benchmark with other locations in the organisation.

Cleanliness, infection control and hygiene

- During our inspection we found the ward and theatres areas were visibly clean and tidy. Cleaning was undertaken by an external contractor through a service level agreement. We saw that cleaning rotas were in place and that these were audited regularly.
- The hospital had an infection control policy (January 2015) and a manual cleaning policy (January 2015) in place and these were accessible to staff.
- The policies included directions on safe working practices, hand hygiene, protective clothing, cleaning policy, waste disposal, MRSA policy, sharps and the labelling, handling and transportation of pathology specimens.
- The infection control lead for the hospital was the clinical services manager. Infection prevention and control was classed as a component of mandatory training for clinical staff.
- Infection control audits were undertaken to assess compliance with infection control practices and procedures.
- We saw that an Infection Prevention and Control Annual Plan and action plan (January 2017 – December 2017) was in place to address issues identified in theatres, preparation, recovery and post operation areas, laser suites, consulting rooms, as well as the general hospital environment. Responsibility for ensuring the annual plan was completed was held by the Infection Control Committee and the Integrated Governance Committee.
- Staff complied with best practice in relation to uniform standards and theatre dress codes.
- There was adequate access to hand gels handwashing sinks on entry to clinical areas and also at the point of care.
- We observed good compliance with hand hygiene and use of personal protective equipment (PPE) used on the ward and in the operating theatre. Hospital audits of hand hygiene showed 100% compliance (September 2017).
- The hospital had one incidence of a healthcare associated infection in the last twelve months – a patient treated in May 2017 reported a three day history of poor vision. The patient underwent a procedure at a local NHS hospital for suspected endopthalmitis (inflammation of the interior of the eye); all other patients treated at the hospital on the same day were contacted and no patient reported any issues or symptoms.

Environment and equipment

- We found clinical areas were well maintained, free from clutter and provided a suitable environment for dealing with patients. Annual environment audits showed 87% compliance in pre-operative areas and 98% in theatres.
- Waste and clinical specimens were handled and disposed of in a way that kept people safe. This included safe sorting, storage, labelling and handling.
- The hospital used single-use, sterile instruments as appropriate. Single use instruments we saw were within their expiry dates. The hospital had arrangements for the sterilisation of reusable instruments which were contracted out and monitored through a service level agreement with an external provider.
- Emergency and resuscitation equipment was accessible in the theatre area. Records indicated that equipment and consumables were checked in line with hospital policy. We checked a sample of consumables and these were in good order and in date.
- The resuscitation trolley was equipped with a defibrillator, oxygen and portable suction and we saw that emergency drugs were stored appropriately in tamper evident bags.
- A designated member of staff was responsible for overseeing and ensuring the maintenance, safety checks and servicing of equipment was undertaken effectively and that an accurate asset register was maintained for all equipment in the hospital. We checked a sample of items in the asset register and saw that these had up to date servicing records.
- We saw service level agreements and maintenance contracts were in place for all equipment and the hospital environment, e.g. deep clean, fire extinguishers, air conditioning, theatre verification, clinical waste and pathology.
- The traceability for implants used in surgical procedures was maintained by retaining the bar codes with unique

traceable reference numbers. These were recorded in patients' medical records. Patients were given a card to keep which contained the barcodes and unique reference numbers for their own lens implants.

- Airflow was maintained in the theatre with up to 25 changes of air per hour, which exceeded the Royal College of Ophthalmologists ophthalmic services guidance on theatres (15 changes of air per hour), the airflow system was tested and serviced annually and we saw evidence of its compliance with required standards.
- The laser room was a large, visibly clean, clinical space with a clinical trolley. The trolley held the laser room checks book and we saw that the room temperature and humidity checks were carried out and dated, timed and signed accordingly. Rooms used for lasers were appropriately equipped, were lockable and had appropriate warning notices and signage.
- Each time the laser was used the temperature and calibration was recorded.
- A laser refractive information booklet was accessible to staff on the clinical trolley. The book included; the safe use of Mitomycin–C, prompt cards for latex allergies, MRSA patient information and management of hypoglycaemia (low blood sugar).
- Local rules were displayed in the laser room and we saw that staff had signed the register to confirm they had read and understood the local rules. All signatures were up to date.

Medicines

- The hospital had a medicine management policy in place (June 2017). This was readily accessible to staff via the organisation's electronic system. A registered nurse was the hospital lead for the safe and secure handling of medicines.
- We saw accurate records were kept when medicines were administered and records included the patient's allergy status.
- The hospital had a service level agreement in place with a pharmacy which included the supply of pharmaceutical products and the provision of monthly medicines management audits to ensure the hospital complied with all regulations and best practice guidelines.
- The latest audits (September and October 2017) showed medicines were kept locked and temperatures recorded and all medicines were in date. The ordering, receipt and disposal of medicines was documented. Patient leaflets were supplied with medication and Medicines and Healthcare products Regulatory Agency (MHRA) warnings were up to date.
- However, medication fridges were not locked. We found medicines openly stored within consultation rooms. This had been identified in the pharmacy audit.
- Areas of non-compliance were flagged to the Clinical Management Team and hospital director through a monthly report. Medicines management was a standing agenda item on all hospital governance and risk meetings.
- Medicines were stored in unlocked fridges and there were processes to ensure they remained suitable for use. Fridge temperatures were checked and recorded daily to ensure medicines that required refrigeration remained suitable for use and room temperatures were checked by clinical staff.
- Staff members were aware of the procedures to follow if temperatures were out of range and contacted the pharmacist to confirm drugs remained fit for use should this occur.
- We checked a sample of medicines and found these to be in date. We were advised that the external pharmacy checked expiry dates, stock reconciliations and provided stock top ups.
- The hospital had reviewed 'Off label/Out of License Drug Use' in January 2017 and this was reviewed annually. This included an identified clinician, governance arrangements and the rationale for use of medications such as chloramphenicol ointment, disport, mytomycin and avastin.
- At the time of inspection, the service was not using cytotoxic medicines as their use had been suspended by Optegra UK in August 2017. The hospital restricted the use of cytotoxic medicines in September 2017 to only sight threatening procedures. Cytotoxic medicines contain chemicals which are toxic to cells, preventing their replication or growth. Managers explained their use was suspended in response to a safety issue which had been identified at another Optegra location following a CQC inspection.
- A new policy and staff competencies regarding the use of cytotoxic medicines had been developed and were due to be implemented in November. Managers told us

that operations that could be completed without using cytotoxic medicines, had gone ahead and where others had been postponed, the service had explained the reasons to patients.

- Following inspection, the service provided a new standard operating procedure, consent form, risk assessment and staff competency for the use of cytotoxic medicines. Managers told us the new process had been piloted successfully and cytotoxic medicines were being used again across Optegra Yorkshire Eye Hospital (OYEH) from November 2017. Feedback was being sought from all Optegra locations and an audit was planned for December, to check the arrangements were effective.
- Patient records showed patients had been appropriately informed about off-licence use of cytotoxic medicines (when they were in use) as part of the consent process and that this was documented in patient records. The Mytomicin C consent form referred to the 'off-label" use of Food and Drug Administration (FDA) approved medicines. The licensing authority for medicines in the UK is the Medicines and Healthcare products Regulatory Agency (MHRA).
- All cytotoxic medicines were prepared aseptically by the manufacturer and no cytotoxic medicines were prepared in-house.
- The pharmacy service had recently provided medicines management training for nursing staff.
- Following surgery nurses were dispensing prescribed medicines from the hospital stock supplies. This was within nurses' scope of practice and covered by a standard operating procedure. The labelling of the medicines described the total amount of medicine supplied and any additional advice such as 'causes drowsiness'.

Records

- We saw that the hospital had both electronic and paper notes which were available for all appointments and surgeries, all patients had a unique ID number which is logged on both electronic and paper records. There was standard operating procedure in place should patients wish to have access to their records.
- Correspondence was sent from the consultant to the patients GP and referring optometrist as appropriate, with a copy to the patient, providing information about the patient's condition and treatment.
- The hardcopy files had colour-coded covers to identify which patients were NHS and which were private patients. This was done so that the correct care advice and referrals could be made.
- The electronic records contained copies of information sent to private patients regarding the costs of their treatment in order to provide the patient with relevant information.
- For surgical patients this involved a physical file containing key records such as the WHO surgical safety checklist, medicine administration records, consent forms and pre-operative assessments.
- Patient risks were assessed and documented on pre-op assessment charts. The details were entered into the electronic system, which took the nurse through standard sets of questions and assessments. The results were then printed and placed in the patient notes highlighting relevant aspects for that patient.
- Patient records included information such as the patient's medical history, previous medicines, consultation notes, treatment plans and follow-up notes.
- The records included information specific to the treatment needed such as the recommended type and prescription of lens to be implanted during surgery based on various test readings.
- The serial number of the implanted lens was logged on the patient's records, as was any other equipment used during surgery. This meant there was an audit trail available that if there were any later issues with implants the patient could be tracked.
- The hospital retained all copies of the patient records and supplied patient information as needed to external professionals.
- The patient liaison staff we spoke with told us they made sure records were available for patients who were attending for surgery by checking the ward staff had these records before surgery took place. We confirmed this during the inspection and observed that records were made available as needed throughout the department. The record then went with the patient into surgery so a contemporaneous record of treatment could be maintained.
- We reviewed a total of five patient records. The records held details of the patient's full medical history in the

hospital, including medicine records, diagnosis and treatment history. We also saw that the records contained observations immediately after surgery in the ward area where patients rested in comfortable chairs.

Safeguarding

- The hospital had a safeguarding policy in place and this had been reviewed and revised regularly and was accessible to staff.
- The hospital had a separate, on-site, safeguarding lead at consultant and also nurse level who were able to provide advice when necessary. There was a national corporate safeguarding lead that was also available to provide advice and oversight.
- Safeguarding vulnerable adults and children was included in the hospital mandatory training programme. The hospital had stopped treating children in the week before inspection.
- Records showed that 90% of all eligible staff in the hospital (including bank staff) had completed safeguarding adults and children level 2 training and 97% of staff had completed safeguarding adults and children level 3 training.
- The registered manager was the safeguarding lead and had completed training to safeguarding adults and children training level 3. Further level 3 training was scheduled for the named nurse and the new clinical service manager.
- Records showed 87% of staff had also completed 'Prevent' counter-terrorism training.
- Staff we spoke with were familiar with their obligations regarding safeguarding and knew what they should do if they had concerns about a patient or their family.
- The service had not reported any safeguarding concerns and there were no safeguarding issues logged with CQC. The hospital director confirmed that there had never been a safeguarding concern in the service.

Mandatory training

- The hospital had a mandatory training policy in place (July 2017). Staff members were required to undertake a range of general and role specific mandatory training modules which were both online and in person. This was in line with the policy and the mandatory training schedule, which set out the frequency that each module was to be repeated.
- Staff received mandatory training in areas such as children and adults safeguarding, infection control, medicines management, fire safety awareness, health and safety, dementia awareness, conflict management, laser safety, medical gas safety, equality and diversity, life support and moving and handling training.
- Training was routinely monitored through the use of a training matrix, which identified when staff training was due for update.
- Records showed the majority of staff had completed their mandatory training. The overall average training completion rate across the hospital was 97% for substantive staff and 91% for bank staff.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- Although the hospital assessed the suitability of each patient on an individual basis it treated all adult ambulatory patients with potential exceptions.
- These included patients classed as American Society of Anaesthesiologists (ASA) level 3 and above, patients with severely limited mobility and those with a body mass index (BMI) above 30. Patients living with dementia, Alzheimer's disease and Parkinson's disease were excluded on the ground of requiring a general anaesthetic. The hospital also excluded patients under 18 years of age (since the start of November 2017).
- The ASA physical status classification system is a system for assessing the fitness of patients before surgery.
- Assessment was undertaken through a 'triage' process upon referral, through the outpatient consultation and through pre-operative assessment processes. The risk of venous thromboembolism was taken as part of the pre-assessment process. The hospital did not routinely calculate BMI and did not use specialist bariatric equipment.
- A staff briefing was held prior to each surgical session. This was attended by all staff involved in the surgery in theatre. The meeting reviewed a brief summary of each patient undergoing surgery and highlighted any specific issues or concerns, such as any notable past medical history or comorbidities, any changes to the theatre list or specific equipment required for a particular case.
- The hospital had a 'World Health Organization (WHO) Surgical Safety Checklist Policy' in place. The WHO checklist formed part of every patient treatment pathway and was audited monthly by the Clinical

Management Team through the documentation audit and the newly introduced 'CREWS' audits which reviewed whether the WHO checklist was carried out correctly.

- Hospital data showed 100% compliance for the audits of the processes in the WHO Surgical Safety Checklist Policy for each month from May 2017 to October 2017.
- We observed procedures and confirmed the hospital was compliant with this policy and the overarching principles of the WHO surgical safety checklist and the National Patient Safety Agency (NPSA) 'five steps to safer surgery' guidance.
- We saw staff introduced themselves to each other by name and role at the briefing and at the 'time out' phase. They recorded information on a visible wipe clean board as per their policy.
- The 'sign in' phase involving the checking of the patient's allergies, confirmation of consent, surgical site marking and patients' understanding of procedure was conducted in the presence of the surgeon and other team members.
- We observed that the 'sign out' procedure was conducted in line with best practice. We were told by staff that debriefs were conducted at the end of lists and we observed a debrief session during the inspection.
- Upon arrival for their procedures the patients were admitted by a nurse. They had their observations recorded, including blood pressure, pulse and oxygen saturations. A temperature was taken if indicated.
- Patients' known allergies were recorded in their records and they were given a red wristband to alert the surgical team that they had an allergy. Their health and past medical history was reviewed and they were asked if anything had changed since their pre-operative assessment. They were also reviewed by the surgeon and anaesthetist where relevant to ensure they remained suitable for surgery.
- During the surgical procedure within the operating theatre, the patient's pulse rate and oxygen saturations were monitored and displayed for team members to observe.
- A staff de-briefing session was carried out at the end of each surgical session to share good practice and highlight learning. There had been no patients transferred to the nearest NHS acute hospital in the last twelve months.
- Information relating to post-operative care was given. Patients who had undergone local treatments at the hospital were provided with comprehensive written patient discharge information. We saw the nurse discharging the patient taking the patient through post-surgery recovery expectations before the patient left and included patient's relatives when appropriate".
- We discussed concerns regarding historic opacification resulting from the use of a particular type of lens. The hospital had stopped using this lens and reported the issue to the manufacturer and the Medicines and Healthcare products Regulatory Agency (MHRA).
- The provider had developed a 'Process for managing patients with suspected opacification' that included counselling and advice, grading of opacification and secondary referral.
- The hospital provided a 24 hour advice line which patients could telephone following their surgery. However, they were advised to seek emergency medical assistance for more serious matters following discharge.
- The hospital had an anaphylaxis policy in place with a standard operating procedure of what should be done in the event of an incident; this was readily accessible and familiar to staff.

Nursing and support staffing

- Staffing was managed jointly across surgery and outpatients. The clinical services manager assessed and anticipated the numbers of staff required based on the number and type of procedures that were being undertaken for that session. This information was then used to plan and the appropriate numbers of nursing staff required.
- The clinical service manager was responsible for ensuring an effective mix of skills and ensuring competence of staff was maintained. The hospital had a 'Theatre safe staffing policy' (July 2017) in place schedule.
- The operating theatre team comprised of a surgeon, a scrub practitioner, a circulating practitioner and a nurse responsible for monitoring the patient.
- Patients were recovered in the ward area where at least one registered nurse was present.
- We saw there were safe numbers of staff on duty to maintain patient safety. Staff and patients reported there were sufficient staff members available.
- Handovers were conducted as necessary where incoming staff were taking over during the course of a patient's treatment, or there was a need to transfer the care of a patient to another nurse.

Good

Surgery

- The hospital did not use agency staff and had its own 'bank' of staff that could be called upon when required. These individuals had experience and knowledge of the hospital and were current or former hospital staff that received the same level of training as permanently employed staff.
- The hospital director told us they had vacancies for a full time nurse and an optometrist at the time of inspection.
- Information supplied by the hospital showed the average rate of sickness absence over the last three months prior to the inspection was negligible (less than 0.1%).

Medical staffing

- The hospital did not directly employ any medical staff but had 23 ophthalmologist consultants who worked across surgery and outpatients under the practising privileges scheme. An anaesthetist was also available for sedation if required.
- Medical oversight was maintained by the Optegra national medical director from whom advice was sought on corporate medical matters. Local medical supervision was available from the medical advisory committee (MAC) chair. The MAC reviewed and monitored clinical practices across the hospital.
- Medical advice was always available during opening hours from the patient's own consultant by telephone if needed. Cover was provided by another consultant with the same sub speciality for any period of absence or leave by individual consultants.
- All consultant applications for practising privileges were signed off by the MAC following review of required documentation. We saw evidence that a robust process operated for the granting of practising privileges. All appropriate checks such as disclosure and barring service (DBS), General Medical Council (GMC), indemnity insurance, specialist registration and health screening were carried out before practising privileges were granted.
- There was more than one consultant practising within each speciality which facilitated access should a consultant be on holiday or not contactable. Consultants had to arrange colleague cover within the hospital ahead of holiday taken.
- Staff had access directly to the operating consultant, in addition to other consultants with practising privileges and the on-call nurse.

Emergency awareness and training

- A business continuity plan was in place which covered potential risks such as dealing with crisis event management, bomb threats, IT system and hardware failures, clinical equipment failure, utilities failure.
- A risk management policy (July 2017) was also in place covering non-clinical risks, such as fire safety. Staff had received fire safety training as part of the mandatory training.
- Evacuation procedures were in place and emergency simulation exercises were practised.
- There was a back-up generator system in place to ensure treatment was not compromised if power to the laser failed mid-treatment.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- The hospital followed national guidance and best practice by the Royal College of Ophthalmologists and National Institute for Health and Care Excellence (NICE) in relation to patient care pathways, cataract surgery, intra-ocular lens replacement, medical retina, glaucoma, cornea and vitreoretinal procedures.
- The clinical services manager in conjunction with the clinical governance committee was responsible for ensuring that the hospital was kept up to date and aware of how new guidance affected clinical practice.
- The hospital had a comprehensive range of local policies and procedures. These were reviewed and updated regularly and reflected current best practice and evidence based guidance.
- The hospital participated in local and corporate audits, which were used to benchmark performance against other Optegra services nationally and internationally.

Pain relief

- Pain relief was administered in the form of anaesthetic eye drops prior to surgery or procedures. Patients were asked about pain levels during and after procedures.

- Patients were consulted, assessed and informed consent taken leading to a care pathway treatment plan.
- Staff could seek advice and input from surgeons where patients complained of pain after surgery in the recovery area.
- Patients were advised on pain relief during discharge discussions and advised on recovering at home. They were given a 24 hour helpline number but we told if the pain was severe they should go to their local accident and emergency department.
- Patients we spoke with stated that their pain was monitored and treated appropriately.

Nutrition and hydration

- Due to the nature of the surgical services offered, there were no specific nutritional or hydration facilities in place. Nursing staff offered drinks and snacks to patients pre and post operatively. Vending machines were located throughout the premises providing refreshment free of charge.
- The needs of diabetic patients were assessed pre-operatively and post-operatively. If they were insulin dependent and required to fast for a procedure the consultant or anaesthetist was able to advise on the number of units of insulin they should take to prevent a drop in blood sugar levels.
- Staff we spoke with were aware of the needs of diabetic patients and would offer appropriate snacks or drinks to patients if their blood sugar levels were low.

Patient outcomes

- The Head of Eye Sciences collated data on refractive lens exchange (RLE), cataract surgery and laser surgery, for all Optegra services every three months. Data collected included operative details; pre-operative, post-operative and clinical outcomes.
- The results showed the hospital achieved no recorded complications for 100% of refractive lens exchange treatments and 99% of treatments for cataract surgery with no recorded complications, during the period between July 2016 and June 2017. This was above industry benchmarks and in line with those achieved by the rest of the UK and international Optegra locations.
- For the same period, the hospital also achieved visual outcomes for cataract surgery patients (e.g. achieving 6/12 or 6/6 corrected vision) which were also above industry benchmarks and in line with those achieved by the rest of Optegra UK locations.
- The hospital produced 'Patient-Reported Outcomes (PROMs)' from electronic satisfaction surveys, administered at follow-up to surgery patients. The PROMs data compared outcomes from April 2017 to November 2017.
- Outcomes for strongly agree/agree for each statement was:
  - I feel my quality of life has improved following treatment (Multifocal IOL implant 100%, Laser vision correction100%);
  - I would recommend treatment to friends & family (Multifocal IOL implant 100%, Monofocal IOL implant 100%, Laser vision correction100%);
  - I am satisfied with the results of my treatment (Multifocal IOL implant 100%, Monofocal IOL implant 100%, Laser vision correction 100%).
- Clinical outcome data showed 98% of eyes 6/12 or better unaided (benchmark 94%) and 84% of eyes 6/6 or better unaided (benchmark 64%) for laser correction. For multifocal intra ocular lens, data showed 98% of eyes 6/12 or better unaided and 80% of eyes 6/6 or better unaided. Data for monofocal intra ocular lens showed 88% of eyes 6/12 or better unaided (benchmark 91%) and 65% of eyes 6/6 or better unaided (benchmark 61%).
- PROM outcomes were discussed at the MAC meeting to benchmark against other Optegra services and other eye services. Numbers of procedures each month were monitored and outliers checked.
- The hospital had agreed Commissioning for Quality and Innovation (CQUIN) national goals with CCGs (July 2017) for flu vaccine, smoking cessation and health inequalities. The hospital was due to submit progress in November 2017.
- The hospital did not routinely submit data to the Private Healthcare Information Network (PHIN) in accordance with legal requirements regulated by the Competition Markets Authority (CMA).

Competent staff

- Any new doctor applying to work at the hospital was discussed at the MAC to consider their suitability

through experience, appraisals and skill levels and determine practising rights. The MAC considered removal from the list if a doctor had not practised at the hospital for 12 months or more.
- Potential new procedures were also discussed at the MAC and had to be signed off by the medical director as safe.
- All new staff completed an online induction programme which included health and safety, system access, mandatory training, human resources and policies and procedures. Staff completed a six month probationary period.
- Competence assessments were carried out for medicines management, theatre and recovery.
- The hospital director told us a new process and competency for the use of cytotoxic medicines had recently been developed. Managers told us staff had completed a 'dry run' of the new process, followed by a pilot procedure in early November 2017. Records showed clinical staff had completed the new individual competency assessments. The hospital director oversaw the pilot to ensure compliance with the new process and provide feedback to further improve the process, before beginning full implementation across the hospital. Managers told us performance against this process would be audited in December 2017.
- An induction booklet was issued to new staff which informed them of the fire evacuation procedures, emergency contingencies, local contact numbers, health and safety policy statements and contractor rules.
- We reviewed five personal files of surgeons and all checks were in order. These included, amongst others; practicing privileges interview forms, ophthalmic surgery certificates and disclosure and barring service (DBS) checks. We also looked at a sample of nursing and support staff files. These were up to date and included information such as professional qualifications and recruitment checks.
- Pre-inspection information showed 100% nursing and medical staff were up to date with their professional revalidation and had their registration checked by the provider within the last 12 months. The ophthalmology consultants working at the hospital were certificated by the Royal College of Ophthalmologists.
- The hospital collected comparative outcomes by clinician and used this for competency and revalidation purposes as well as for quality improvement processes through the MAC and clinical governance processes.
- Registration and revalidation, where applicable, were checked and recorded for every member of staff.
- Consultants declared specific procedures they carried out as part of their regular practice, in their practising privileges application. Consultants who did not carry out treatment over a twelve month period had their practising privileges reviewed by the MAC.
- We saw confirmed all consultants and clinical team members had received 'Core of Knowledge' training monitored through the hospital training tracker on the intranet. Training was provided by manufacturers when new refractive lasers were introduced.
- Records showed 82% of staff had received an annual appraisal. The hospital's annual appraisal programme ran from July to June each year.

Multidisciplinary working

- During our inspection we saw effective multidisciplinary teamwork between disciplines within the hospital. There was a sense of respect and recognition of the value and input of all team members.
- A number of staff were able to work across the hospital covering both surgery and outpatients. This meant that staff were able to demonstrate an understanding of different roles and collaboration with colleagues.
- Within theatres staff stated teams worked well together and all members of the team had a voice. Staff said that all grades of staff were able to have their opinions heard.
- The hospital had effective external working relationships through service level agreements with external contractors to facilitate the effective running of the hospital. This included the provision of pharmacy services, clinical waste management and disposal, laundry, cleaning and estates management.
- The hospital had effective relationships with community eye practitioners such as optometrists, opticians and community nurses.

Access to information

- The hospital used an electronic based clinical record, accessible from both the hospital and all other Optegra locations. All patient administration, including patient, GP and consultant letters were held within the electronic patient administration system.

- The same consultant saw the patient from initial consultation through to surgery and post-operative appointment ensuring continuity of care.
- If a patient experienced a post-operative complication, the unique patient ID number was used to determine any required information and access the electronic record system. The electronic database enabled messages to be sent requesting the on-call clinical team to contact the patient.
- Patient records were both electronic and paper based. All staff had access to full details of a patient's past medical history, medicines, allergies, referral letters, consent information, clinic notes, pre-assessment notes, and consultants' operation notes.
- Paper records were kept on site for three months before being archived to an external storage facility. Documents could be recalled should they be needed after being archived.
- Staff had access to the information required to undertake their role. They had access to a range of policies, standard operating procedures and open source material through the online system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A corporate consent policy was in place at the hospital. The policy was compliant with Mental Capacity Act and Deprivation of Liberty Safeguards legislation.
- The policy set out staff responsibilities for seeking and obtaining informed consent, including the type of consent (verbal or written) needed for different procedures undertaken at the hospital.
- Training on Mental Capacity Act and Deprivation of Liberty Safeguards legislation formed part of the safeguarding vulnerable person's mandatory training module and dementia awareness was provided as a separate module.
- The responsibility for consent to procedures was undertaken by consultants, this took place at consultation and confirmed immediately prior to procedure. All patient records we looked at had completed and signed consent forms.
- The capacity of a person to consent to treatment was reviewed by consultants and staff nurses during consultation and the pre-operative assessment stage.
- For elective procedures undertaken at this hospital, best practice guidance suggests that practitioners should allow a minimum of one week between the date of consultation where they agreed to a procedure and the date the procedure is undertaken. Staff we spoke with were familiar with 'cooling off' periods and we saw that minimum cooling off periods of at least one week were observed.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- All staff were observed to be friendly towards the patients and treated them with respect and dignity. We observed staff providing care and speaking to patients in a respectful manner.
- We spoke with three patients and the relatives of two patients. They all said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained.
- The comments received included: "staff are friendly, polite and respectful"; "a very positive experience" and "staff explain everything fully".
- Two patients commented that they had experienced delayed waits whilst waiting on the day of their appointment. They told us there was minimal communication about how long the delay will be.
- Staff carried out monthly patient satisfaction surveys to obtain feedback from patients and identify improvements to the service. The patient experience survey 2016/2017 showed 97% of patients would recommend the hospital to family and friends (81% highly likely to recommend).
- We observed that the privacy and dignity of patients was maintained at all times, with consulting rooms available for private discussion with staff. We observed staff introducing themselves and wearing name badges during our visit, as per the Optegra privacy and dignity policy.

Understanding and involvement of patients and those close to them

- Patients we spoke with during inspection said they felt involved in decisions about their care and did not feel any pressure to make decisions or accept treatment.

- Patient records recorded that consultants ensured that patients had realistic expectations of their procedure and understood treatment options before consent was obtained.
- Patients were offered a 'cooling off' period' of at least seven days, to ensure that they had fully understood and considered all the information available.
- On the day of surgery, we found staff explained what was happening during each stage of the procedure and checked that patients understood the treatment process.

Emotional support

- Staff demonstrated empathy and understanding about the emotional impact that sight problems might have on patients.
- We observed staff provided reassurance to patients who were undergoing procedures. They supported nervous or anxious patients by putting them at ease and calmly explained the procedure.
- Patients spoke positively about the care and treatment received and told us their emotional needs were fully met by staff.

Are surgery services responsive?

Good

We rated responsive as good**.**

Service planning and delivery to meet the needs of local people

- The hospital delivered care and treatment in pleasant, appropriate and well maintained premises, with excellent facilities for patients and staff.
- The hospital assessed the requirements of their private and insured patients, the requirements of the local clinical commissioning groups and their potential patients when designing, furnishing and equipping the premises. The individual needs of all patients were assessed at a pre-operative appointment.
- A daily CREWS (Caring, Responsive, Effective, Well Led and Safe) checklist was carried out to ensure the safety of the premises was assessed. Regular governance meetings included the monthly integrated governance and quarterly infection control meetings to discuss concerns, share learning and create actions for improvement. These were attended by functional Heads and key personnel, including external advisors as appropriate.
- The hospital provided pre-planned care and treatment only. They were in full control of the numbers of patients they could accommodate at any given period. The hospital proactively forward planned surgical and clinic sessions and used data to identify number of patients waiting for treatment and procedures.
- The hospital decreased or increased the number of surgical sessions and clinical appointments required to meet the needs of patients and to maintain flexibility at busy periods. A dedicated appointment schedule meant patients accessed the hospital in a timely way and evening and weekend appointments were also available.
- If a surgeon had planned time off then theatre list would not be compiled for those days and in turn if increased numbers of patients were waiting extra sessions could be organised, for example at a weekend.
- The hospital had two operating theatres.
- The hospital was open six days per week: Monday, Wednesday, Thursday from 08:00 to 20:00, Tuesday from 08:00 to 21:00, Friday 08:00 to 18:00 and Saturday from 08:00 to 12:00.
- The hospital provided a 24 hour helpline for advice to patients outside of normal working hours. Consultants were available during normal working hours to review patients if staff felt medical input was required.
- Self-pay and insured patients were either referred by their GP, optometrist or through self-referral. Details were logged on to the patient database and confirmation of the appointment sent out.
- The hospital had been assessed for compliance with the Department of Health 'Eliminating Mixed Sex Accommodation'(EMSA) guidelines. Records showed the hospital had not reported any mixed sex breaches between April 2017 and October 2017.

Access and flow

- Patients were able to access the hospital via a range of means. Self-paying and insured patients were able to self-refer without a GP or optician's referral. Local NHS clinical commissioning groups (CCG) commissioned services from the hospital for appropriate NHS patients.

Good

Surgery

- All NHS referrals were booked through the patient database following the NHS patient pathway which included triage by a member of the clinical team. Patients were notified of their appointments by the hospital team.
- All new appointments were backed up with a welcome call to reassure the patient of their appointment, the letter also included a map of the hospital with directions and parking information and a patient registration form and a medical questionnaire.
- Each patient had a 'Patient Liaison' who liaised between the consultant and patient should there be any queries or concerns that need to be addressed.
- As part of the data required by NHS contracts the hospital was required to meet the 18 week referral to treatment (RTT) pathway.
- Hospital data showed that the average waiting time for NHS patients from referral to treatment was approximately seven weeks (54 days); 93% of NHS patients received treatment within 120 days of referral. Hospital data showed that the average waiting time for private patients from referral to treatment was approximately eight weeks (56 days); 91% of private patients received treatment within 120 days of referral.
- All patient treatment was scheduled in the same way regardless of being NHS or self-funded patients and medically urgent patients were treated as a priority.
- Waiting times were audited through patient satisfaction surveys and action plans were produced and discussed at the MAC.
- NHS patients followed the NHS patient pathway which included an assessment of suitability and triage by a clinician. These patients required a GP or optometrist referral. For some procedures NHS patients could choose this hospital through the NHS e-referral programme (formally known a 'choose and book').
- Managers told us it was not possible to retrieve information on the number of cancellations or patients that did not attend appointments, using the patient information system. However, managers told us no cancellations of outpatient appointments had been reported via the incident reporting system and Optegra UK was looking into the system data issue. Private patients were able to arrange a free, no obligation consultation with ophthalmologists to discuss potential treatments and procedures. They could also attend 'open evenings' where consultants gave a presentation and discussed the various treatments on offer.
- The hospital did not provide an emergency eye surgery service. They provided for elective and pre-planned procedures only. Any emergency cases were referred to the appropriate emergency eye care services.
- Discharges following surgery were undertaken by nurses following assessments of the patient's recovery and fitness to go home. If nurses had any concerns they requested a review by the surgeon involved.
- Discharge letters were completed and copies sent to the patient's GP and a copy given to the patient. The discharge letter outlined the completed procedure, medication and details of any treatment plan or post-operative care and follow up.
- Patients were advised regarding post-operative care, how to use medicines provided and given details of the 24 hour helpline should they have concerns following discharge.
- Follow up appointments were arranged as outpatients at clinic for reviews and dressing changes.
- Hospital data showed there had been no cancellations for surgery or rescheduled surgery from the beginning of July 2017 to the end of September 2017.

Meeting people's individual needs

- The hospital provided surgery for both private and NHS patients and the patient mix for the last 12 months was 70% NHS patients and 30% privately funded.
- Patient language, interpretation and chaperone needs were covered in the hospital policy on 'Equality, inclusion and human rights'. Staff were able to access language and interpretation services. The policy had information for staff for using interpretation services.
- Information leaflets were available but the information and materials we saw was in English only.
- A loop system was in place for hearing aid users.
- The hospital was accessible for patients with mobility issues and wheelchair users. There were designated disabled car parking spaces and step free access to the hospital. There were designated disabled bathroom facilities on site.
- Less confident patients were invited for a trial visit.
- The hospital provided online learning and workshops to discuss key issues and share learning with regards to dementia awareness and safeguarding vulnerable adults. An individual consent form was available for patients lacking capacity.
- The hospital 'Patients Guide' was available throughout the hospital.

Good

Surgery

- Following surgery, patients were provided with written information explaining follow-up care and contact details of who to call if they had concerns. Patients were also offered a follow-up appointment the day after surgery to check on their progress.
- All providers of NHS care must follow the Accessible Information Standard from 1 August 2016. This requires services to identify, record, flag, share and meet the information or communication needs of people with a disability or sensory loss.
- Staff told us that if a patient had any additional needs, this would usually be recorded on the hospital electronic record system and may be identified at GP referral. We saw there was the facility to record whether a patient had hearing difficulties, speech or language difficulties, mobility problems, or needed assistance in the department. The system had the facility to create an alert to flag needs, although this was not routinely used on this way. Paper records did not readily flag or highlight additional needs. Staff told us that while they would work to make adjustments on the day, they would not routinely anticipate a patient's additional needs before arrival in clinic, meaning additional time or resources were not allocated. Some staff were unsure whether a hearing loop was available in the department. The patient booking system did not currently share information with other healthcare providers about patients' communication needs.
- The provider was only partly meeting the accessible information standard, as patient information and communication needs were not routinely flagged, shared or met.

Learning from complaints and concerns

- The hospital had a complaints policy in place, this was in date, reviewed and updated regularly and was accessible to staff.
- Complaints were captured, tracked and reported via the intranet. Where possible, patient concerns were resolved informally by discussing the issue with a member of the hospital team. If the issue remained unresolved the complainant was invited to follow the formal complaint procedure.
- The patient was given a copy of the hospital complaints process detailing how to take their complaint further. A letter confirming receipt of the complaint was sent out within two working days. A full response was expected to be made within 20 working days of receipt of the complaint.
- Any extension of the deadline was agreed with the complainant. The outcome of the investigation and detailed response was sent to the complainant no later than five working days following conclusion. An appeal can be made to the provider's managing director.
- We looked at the hospital's complaints tracker which showed they had received 15 complaints within the last twelve months. These had been investigated, eight upheld, two partially upheld, three not upheld and two not yet determined.
- The process at the hospital was to refer complaints to the patient services manager and the hospital director, who reviewed and escalated the complaint to the operations director, if necessary.
- Details of complaints were discussed at the Medical Advisory Committee (MAC) and integrated governance meetings. Informal complaints were shared at the daily huddle.
- Patients were advised they were able to complain to the Independent Sector Complaints Adjudication Service (ISCAS) for an independent review. Details of how to do this were in the Optegra 'Feedback, comments & complaints' booklet.
- The complaints policy did not make reference to the Parliamentary and Health Service Ombudsman (PHSO) but referred to the Care Quality Commission in relation to patients that were not satisfied with the way their complaint was managed.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- The hospital management structure included a regional director, hospital director, patient services manager and a clinical services manager.
- The patient services manager had responsibility for patient liaison staff, patient services advisors and

support staff such as housekeepers and receptionists. The clinical services manager had responsibility for registered nurses, healthcare technicians, the theatre team, optometrists and orthoptist.

- We interviewed the management team who outlined their vision and priorities for the hospital. This included encouraging continuous improvement and learning, team support and development, robust performance management based on patient outcomes and good governance.
- The provider expected every manager to promote equality inclusion and human rights and prevent discrimination. This responsibility was outlined in the 'Equality, inclusion and human rights' policy (July 2017).
- The hospital complied with the requirements of the Equality Act (2010) including how they met the duty to eliminate unlawful discrimination, harassment and victimisation, advanced equality of opportunity between people who share a protected characteristic and the general population and foster good relations between people who share protected characteristic and people who do not share it.
- The management team had prioritised the delivery of a plan to ensure continued high quality service delivery that supported regulation compliance including focus on CQC key lines of enquiry, action planning for continuous improvement and colleague engagement and involvement.

Vision and strategy for this core service

- Optegra's vision was '…to ensure Optegra UK is a market leading profitable provider of first choice, famous for patient service and eye care excellence because we look after our colleagues, who look after our patients'.
- The provider had published shared values which described how staff behaved towards patients and one another and impact positively on the quality of life of the patient and drive business success.
- The provider statement of purpose described a corporate vision and values and the objective to be the 'most trusted' eye care provider with the aim to put the patient at the centre of services.
- The provider aspired to provide the appropriate service and care for the patient in the best environment and at the right time.
- The values and objectives had been cascaded to staff across through appraisal objectives and staff had a good understanding of these.

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

- The hospital held clinical service managers (CSM) meetings quarterly, which were attended by the corporate clinical lead and head of clinical governance and risk, together with all CSM's from UK Optegra services.
- Key areas discussed were medicine management, infection control, safeguarding, clinical incidents and health and safety.
- The CSM meetings ensured commonality across the services, shared pathways, documentation and encouraged staff recognition of their relationship with the provider. Minutes demonstrated evidence of shared learning.
- The provider had introduced a local balanced scorecard that measured 'Key Performance' across all areas including colleague satisfaction, impact on patients, processes and financial performance. This incorporated eleven metrics and was benchmarked monthly against best practice.
- Weekly operational review calls and monthly Operations Meetings were held across Optegra's seven hospitals to share insight and benchmark across all hospitals.
- A governance structure was in place to ensure information and learning was cascaded up to the provider's board.. Audits were conducted in line with national standards.
- The outputs from the governance groups were reviewed to ensure consistency, monitor trends and adherence to policy and outcomes data, complaints and serious incidents were also reviewed. We saw evidence of this by reviewing the minutes to the last three meetings.
- Surgical outcomes were collated by the provider's Eye Sciences division and shared with the Hospital Director. They were discussed and reviewed at the MAC, with individual consultants, and at the corporate Governance Committee on a Quarterly basis.
- Quality clinical reports were discussed at the local Governance Committee and the local MAC – agenda items included incidents, never events, SUIs, returns to theatre, unplanned outpatients, transfers and duty of candour.

- The risk register accurately reflected risks within the hospital. The risk register described the cause and consequence of this risk. The type of risks were categorised as financial, quality or operational.
- Specific risks identified were theatre recruitment, medication for non-standard procedures, consultant management and patientoutcomes and the hospital structure.
- The MAC met quarterly and was attended by the chair, an optometrist, clinical nurse, consultant and a spread of sub-specialities for glaucoma, refractive eye surgery, cataract, cornea and retinal. Safety, adverse events, infections, complaints and incidents were discussed and learning taken from critical incidents and events.
- The Workforce Race Equality Standard (WRES) is a requirement for organisations, which provide care to NHS patients. This is to ensure employees from black and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.
- WRES has been part of the NHS standard contract, since 2015. NHS England indicates independent healthcare locations whose annual income for the year is at least £200,000 should produce and publish WRES report. The provider submitted a Workforce Race Equality Standard (WRES) action plan with regards to monitoring staff equality to the clinical commissioning group (CCG) as part of their contractual arrangement
- Consultants working under practising privileges had their own indemnity insurance in place.
- The hospital was working towards 100% mandatory training completion, consistent achievement of 100% compliance against Optegra's National Audit Plan, and an increased focus on reducing the length of time that a patient waits to be seen at the hospital.

Public and staff engagement

- The hospital had a website where full information could be obtained about the treatments available for patients. It was very comprehensive including information about costs and finance.
- Patient views were sought in a number of ways, e.g. electronically, survey, comment books and a friends and family test. The patient experience survey (2016/2017) showed 97% of patients would recommend the hospital to family and friends (81% highly likely to recommend).
- Patients commented that the hospital was '…clean hospital, nice staff, friendly welcome', '…good all round treatment and service' and '…extremely helpful, relaxed atmosphere, everything explained in full'.
- Regular refractive open evenings were held enabling patients to meet prospective consultants, receive procedure information, ask questions and tour the hospital.
- The Eye Sciences division had developed a patient questionnaire for those who had undergone cataract surgery, laser vision correction or refractive lens exchange. The questionnaire was developed to be delivered by a touch screen tablet or through a paper version was available.
- A patient forum was not in place at the hospital. Patient forums are usually open to any patient or relative to discuss any concerns or anxieties they may have about the hospital and treatment.
- The hospital developed an action plan (March 2017) from the results of the 2016 staff survey. This highlighted a number of issues about clarity on targets and progress, information technology, job satisfaction, infrastructure, communication between teams and staff shortages. The action plan identified outputs for each action, responsibility and timescales.
- Staff huddles took place daily at 10am where staff were informed of who the theatre lead was for the day, anticipated visitors to the service, roles and responsibilities of staff and other relevant information that needed sharing.
- The provider ran a staff recognition scheme where staff could nominate individuals and teams.

Innovation, improvement and sustainability

- The Eye Sciences division managed the collection and reporting of clinical data for all locations. The team also audited against services outside the UK, which included Poland, Czech Republic, China and Germany. The data covered clinical complications, visual and refractive outcomes for laser, lens replacement and cataract patients, to an agreed protocol.
- Data was captured using an electronic patient record (EPR) system enabling the benchmarking of performance and patient outcomes across Optegra locations and internationally.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

The main service provided by this hospital was surgery. Where our findings on out patients and diagnostic imaging, for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the surgery section

We rated safe as good.

Incidents

- The hospital had no serious incidents reported during the last twelve months. The incident log (2017) showed 7 incidents recorded for 'clinical-outpatient' and 8 incidents recorded for 'admin' relating to outpatients. The incidents ranged from equipment and IT failure, booking errors where insufficient time was allocated for appointments, to medical records error, failure to send a GP letter in a timely way, and a sharps injury during waste disposal.
- There were systems in place to investigate, incidents, carry out root cause analysis and identify learning outcomes, as required.
- There had been no 'never events' reported during the last twelve months. Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations have been implemented by healthcare providers.
- For our detailed findings please see the Safe section in the surgery report.

Cleanliness, infection control and hygiene

- During our inspection we found the outpatients waiting area and consultation rooms were visibly clean and tidy.
- Outpatient's staff complied with best practice in relation to uniform standards and theatre dress codes.
- Infection control audits were undertaken to assess compliance with infection control practices and procedures and an annual infection control plan was in place.
- There was adequate access to hand gels, on entry to reception and outpatient waiting areas and gels and hand washing sinks in consultation rooms, at the point of care.
- We observed good compliance with hand hygiene and use of personal protective equipment (PPE) used in outpatient areas.
- Waste bins were operated hands-free, suitable waste bins were available for sharps and a service level agreement was in place for collection and disposal of clinical waste.
- We reviewed cleaning schedules and found them to be signed and up to date, with instructions for staff. There was a service level agreement in place for domestic cleaning.
- For our detailed findings please see the Safe section in the surgery report.

Environment and equipment

- The outpatient environment was tidy and free from clutter, enabling patients, visitors and staff to move around freely.
- An environmental audit was completed which showed 86% compliance in outpatients (July 2017) and we saw actions fed into the Yorkshire action plan to address issues identified.

Good

Outpatients and diagnostic imaging

- We looked at clinical areas including examination rooms, consultation rooms and the laser room. Clinical areas were observed to contain equipment that was suitable to the diagnosis, examination and treatment of patients.
- Records available indicated that the service had a schedule for routine maintenance and equipment checking, including for the laser used in the department.
- We saw controlled areas were clearly defined and a digital lock was used to keep the laser room in outpatients secure.
- There were local rules in place for laser safety available in the laser room. We saw evidence that all relevant staff had read and signed the 'Local Rules'. This was in line with the Medicines and Healthcare products Regulatory Agency Surgery (MHRA) guidance on lasers, intense light source systems and light-emitting diodes (LED's) – guidance for safe use in medical, surgical, dental and aesthetic practices (September 2015).
- Each patient who received laser treatment was logged into the treatment book in the laser room, with the procedure performed and patient ID labels, although the consultant name was not always legible.
- Resuscitation equipment was available for use in an emergency and records showed daily checks were completed.
- For our detailed findings please see the Safe section in the surgery report.

Medicines

- Optometrists, nurses and consultants gave medicines such as eye drops, IV medicine and tablets from the hospital stock supplies.
- We saw that the labelling of the medicines described the total amount of medicine supplied and any additional advice such as 'keep out of reach of children'. Patient information leaflets were given with medicines. An eye drop instructions card was also given, with written information for patients on care and use of eye drops as well as the name of each medicine, how often they were to be used and in which eye.
- The pharmacy service had recently provided medicines management training for nursing staff and the pharmacist highlighted dispensing as an area for clarification. We noted that dispensing medicines was raised at the integrated governance meeting in October 2017, for addition to the risk register, as it had been highlighted as an area for improvement in a recent audit.
- Patient records detailed current medicines, any allergies and a medical history to make sure that any medicines prescribed by the consultants were safe to be given.
- The most recent audit (October 2017) showed medicines were kept locked and temperatures recorded and all medication was in date. We checked a sample of medicines and found these to be in date. We were advised that the external pharmacy checked expiry dates, stock reconciliations and provided stock top ups.
- The ordering, receipt and disposal of medicines was documented. However, we found some medications openly stored within unlocked consultation rooms. Staff advised cupboards where medications were stored should be locked at the end of clinic sessions although consultants did not always advise nursing staff when their clinics had ended, so they could do this.
- For our detailed findings please see the Safe section in the surgery report.

Records

- The service used a paper medical record system, supported by an electronic system. The paper record was the primary record. Notes were kept within the department and made available as needed. Electronic records were only accessible to authorised people. Computers and IT systems used by outpatient's staff were password protected.
- Staff told us archived records could be retrieved within the hour. Occasionally, patients from Optegra Leeds were seen at Optegra Yorkshire Eye Hospital and there was a new policy was in place for secure transfer of medical records between sites.
- We reviewed four patient paper records and two electronic records. Paper records included information on the patient's medical history, referral form, prescription charts, investigations and consultation notes, treatment plan and consent form, in order to keep the patient safe and to determine suitability for treatment. The treatment pathway, follow-up notes and correspondence with the patient's GP were also recorded. The electronic records system included an alert facility, for example which could be used to identify patient allergies.

- A patient telephone advice record sheet was used to log patient calls in their notes and pre-printed labels were used to identify records.
- The audit plan identified patient records were audited every six months. We saw that ten sets of records were audited in September 2017 and compliance varied on the criteria checked e.g. legible handwriting 40% compliance; consent recorded appropriately 100% compliance. Managers confirmed that legibility of documentation was an area for improvement.

Safeguarding

- The hospital had stopped treating children as outpatients, in the week before inspection, although 77 children (under 18) were treated as outpatients at the hospital over the past 12 months. These patients were seen by an orthoptist or an ophthalmic consultant for problems relating to the movement of the eyes, such as squint and problems with ocular motility.
- Records showed that 90% of all eligible staff, including outpatient's staff, had completed safeguarding adults and children level 2 training and 97% of staff had completed safeguarding adults and children level 3 training.
- The registered manager was the safeguarding lead and had completed training to safeguarding adults and children training level 3. Further level 3 training was scheduled for the named nurse and the new clinical service manager.
- Nursing staff we spoke with were familiar with their obligations regarding safeguarding and told us they would contact the named nurse lead, if they had concerns about a patient or their family. Patient liaison staff were aware of how to obtain further advice or support.
- The service had not reported any safeguarding concerns and there were no safeguarding issues logged with CQC. The hospital director confirmed that there had never been a safeguarding concern in the service.
- The hospital were developing links with the local authority safeguarding network and this work was discussed at the huddle meeting we observed.
- For our detailed findings please see the Safe section in the surgery report.

Mandatory training

- For our detailed findings please see the Safe section in the surgery report.

Nursing and medical staffing

- Staffing was managed jointly across surgery and outpatients. The clinical services manager assessed and anticipated the numbers of staff required based on the number and type of appointments needed in each clinic. This information was then used to plan and schedule the appropriate numbers of nursing staff required.
- The clinical service manager was responsible for ensuring an effective mix of skills and ensuring competence of staff was maintained. The hospital had an outpatients staffing protocol (June 2016) in place. The core staffing for the outpatients team comprised a registered nurse, a healthcare technician and an optometrist. The numbers were increased as required. Due to the size and nature of the service provided, it did not use a formalised staffing acuity tool.
- The hospital was open six days per week: Monday, Wednesday, Thursday from 08:00 to 20:00, Tuesday from 08:00 to 21:00, Friday 08:00 to 18:00 and Saturday from 08:00 to 12:00. A registered nurse was always scheduled for duty whilst the hospital was open and would respond to patient calls for advice.
- Staffing levels we observed were appropriate for the type of service offered, there was no agency use and sickness absence was below 1% for the reporting period.
- Consultants worked across both Optegra Yorkshire Eye Hospital (OYEH) and Optegra Leeds and nurses travelled between sites as necessary. The hospital had its own 'bank' of staff that were called upon when required in outpatients. These individuals had experience and knowledge of the hospital and were current or former hospital staff. These flexible arrangements meant the service did not use agency or locum staff during the reporting period.
- The hospital did not directly employ any medical staff but had 23 ophthalmologist consultants who worked across surgery and outpatients under the practising privileges scheme.
- A standard operating policy was in place for managing clinical on-call.
- For our detailed findings please the Safe section in the surgery report.

Emergency awareness and training

Good

Outpatients and diagnostic imaging

- Fire safety arrangements were in place in the department, staff had received fire safety training as part of the mandatory training. Staff were aware of the evacuation procedure and the location of the fire assembly point.
- For our detailed findings please see the Safe section in the surgery report.

Are outpatients and diagnostic imaging services effective?

We inspected but did not rate the effective domain for outpatients and diagnostic imaging..

Evidence-based care and treatment

- The hospital followed national guidance and best practice by the Royal College of Ophthalmology and National Institute for Health and Care Excellence (NICE) in relation to patient care pathways, cataract, medical retina, glaucoma, cornea and vitreoretinal procedures.
- For our detailed findings please see the Effective section in the surgery report.

Pain relief

- The outpatients department provided limited forms of pain management due to the type of service. Pain relief was administered in the form of anaesthetic eye drops prior to procedures.
- Patients told us they received good support from staff and their pain symptoms were effectively managed.
- For our detailed findings please see the Effective section in the surgery report.

Nutrition and hydration

- Due to the nature of the outpatient services offered, there were no specific nutritional or hydration facilities in place. Drinks and snacks were available in the waiting area for patients, free of charge.

Patient outcomes

- For our detailed findings please see the Effective section in the surgery report.

Competent staff

- Staff training and appraisal was managed jointly with surgery. For our detailed findings please see the Effective section in the surgery report.
- Competence assessments were carried out for outpatients nursing staff for intravenous cannulation and safe use of sharps.
- The laser protection supervisors (LPS) had completed 'Core of Knowledge - Laser Safety' training and are supervised through a service level agreement with an external laser protection advisor.
- Public Health England (PHE) reviewed competency, local rules, provided training and carried out an annual audit of the LPS competence, laser checks and safety.
- The hospital register of authorised users identified all consultants who operated laser equipment and clinical team members who assisted with the procedure. All registered users signed to confirm they had read and understood the local rules for each laser room and procedure.
- The 'Laser Safety Management File' and local policies in each laser room held the contact information for the Laser Protection Adviser (LPA). The LPA reviewed the file during each audit or when a change happened. The local Laser Protection Supervisor liaised with the LPA should any change occur during the year to ensure all information was up to date.
- Two Laser Protection Supervisors were in place for the hospital. All clinical team members had undertaken laser 'Core of Knowledge' training which ensured competence in laser safety. There was a competent clinical member of the team in the hospital when any laser procedure took place.
- The registered manager told us the ophthalmic consultant and orthoptist that had treated children during the past 12 months were paediatric-specialty trained. We found that the consultant was up to date with their mandatory training, including safeguarding training. We saw the orthoptist did not have evidence of up to date paediatric life support training although the registered manager told us this was booked for November 2017. The service did not employ a paediatric nurse.

Multidisciplinary working

- During our inspection, we saw there was a sense of respect and recognition of the value and input of all team members. Outpatient staff told us there was effective multidisciplinary teamwork between disciplines in the team.
- A number of staff regularly worked across both Optegra Yorkshire Eye Hospital (OYEH) and Optegra Leeds

locations. Staff explained that this meant they worked well together as a team to deliver both the refractive (laser) eye service and other types of surgery and outpatient appointments at OYEH.
- For our detailed findings please see the Effective section in the surgery report.

Access to information

- Staff usually had access to all the information required to undertake their role, although staff told us there had been incidents where IT problems, meant appointments could be delayed. For example, staff also told us that when the IT system was not working properly, there could be a delay in transferring images from diagnostic equipment to the patient record for consultant review. We saw that some IT problems had been reported via the incident management system. However we also found that staff had occasionally taken a photo of a test image, using a mobile phone, to show a consultant in the next room and avoid a delay to consultant appointments. However, this was an information governance risk. When raised with managers on inspection, this was addressed with consultants and staff.
- During our unannounced inspection, we saw that staff were recording how much time was spent on IT problems, so managers could assess and find ways to address the problems identified.
- The same consultant saw the patient from initial consultation through to treatment and follow-up appointments ensuring continuity of care.
- If a patient called for advice following an appointment, the unique patient ID number was used to access the electronic record system, which enabled messages to be sent requesting the clinical team to contact the patient.
- For our detailed findings please see the Effective section in the surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that ten sets of patient records were audited in November 2017 and overall compliance was 85% and compliance varied on the criteria checked. For example, 100% of records showed evidence that the intended benefits and the potential risks of the procedure had been discussed with the patient and the consent form been signed by the health care professional. However, some records did not comply with stage one of the informed consent process to allow enough time for the patient to make an informed decision or receive further information prior to procedure (70% compliance), and in some records, any extra procedures known about prior to surgery had not been recorded on the consent form. The audit noted that 50% of records did not have the stage 2 part of the consent form completed prior to treatment (patient confirmation) and in 50% cases a signed copy of the consent form was not given to the patient.
- Actions were identified to share the audit results to all consultants, for the CSM to discuss specific findings with individual consultants and to repeat the audit in December.
- Staff told us patients were advised about side effects of medicines as part of the consent process, for example from IV medicines used in a type of imaging. We reviewed two patient records and saw that one patient had been appropriately informed about potential side-effects of IV medicines used in angiography, as part of the consent process, and one had not, even although the same consultant had seen both patients. Similarly, for one patient, there was a note to say a patient information leaflet had been given and one there was not. The leaflet for the IV medicine included information on side effects, although the patient record did not detail which patient leaflet was given which meant the service could not check whether appropriate patient information (e.g. information leaflets) had been given to the patient.
- Although there was no separate consent sought from patients to store images taken during diagnostic tests, we did see a patient information leaflet about the IV angiography procedure which explained that images will form part of a patient's medical record and as such, the consultant will see them.
- For our detailed findings please see the Effective section in the surgery report.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

Good

Outpatients and diagnostic imaging

- All staff, including reception staff and non-clinical staff, were observed to be compassionate and respectful to every patient who used the service. Patients and relatives told us that staff were always friendly and respected their dignity. We observed this in action during the inspection. We observed that staff and consultants introduced themselves when patients were called from the waiting area, for their appointment.
- Patient survey data showed 98% of patients across the UK would recommend Optegra to a friend or family member (from 394 patient responses from 26 June to 3 November 2017).
- We spoke with five patients during the inspection and we received eight comment cards from patients, seven of which gave positive comments about the care they had received.
- Patients commented on the quality of staff, care received and hospital cleanliness, for example; 'a splendid hospital, friendly staff and competent surgeons', extremely good care in clean, comfortable room,' 'clean, pleasant waiting rooms, considerate staff'.
- However, two patients commented on communication regarding waiting times in the department. One patient comment card said there was; 'a long delay second time' and another stated; 'long delay. No communication by staff as to how long delay will be.'

Understanding and involvement of patients and those close to them

- Patients told us they were involved in the decisions made about their care and treatment on the day of their surgery. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choices of treatment available.
- Patients told us that staff explained the risks and benefits of their procedure and they were given verbal information and support regarding their treatment.

Emotional support

- We observed staff giving reassurance to patients in a calm and relaxed manner.
- One patient who completed a comment card said; 'My treatment was very swift and the care excellent. I can't thank Optegra enough and especially my surgeon. He gives off great confidence and concern.'

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The service was designed to provide outpatient clinic appointments for adult patients across a range of specialties, including acute macular degeneration, cataract care, vitrectomy, glaucoma, and ocular plastics. Adult patients were seen from across Yorkshire. It also accepted patients from outside of this area.
- All appointments and treatments were pre-planned and delivered on a day-case basis. The service did not accept children or patients who may require an overnight stay.
- The hospital had previously provided outpatient services for children. This service had been suspended a week before the inspection. 77 children (under 18) were treated as outpatients at the hospital over the past 12 months. These patients were seen by an orthoptist for problems relating to the movement of the eyes, such as squint and problems with with ocular motility.
- There was an admission and discharge policy which set out the treatments available across Optegra Yorkshire Eye Hospital (OYEH) and stated patients considered for admission must be over 18 years of age and a full health assessment must be undertaken by the admitting consultant to assess suitability.
- Following inspection, the service provided further information which showed that a patient would not be able to access OYEH services if they required a general anaesthetic for a procedure, if they were not in good health (e.g. ASA level 3 severe systemic disease); if they had a BMI greater than 30; if they had severely limited mobility; or, were living with dementia or Parkinson's disease.
- If a patient required surgery under general anaesthetic, or a different procedure not provided by the hospital, they would either be referred back to the NHS or to another Optegra service, to ensure their needs could be met appropriately.

- If a patient required refractive (laser) surgery, this would be carried out at Optegra Leeds, although initial or aftercare appointments could be carried out at OYEH, on occasion, at patient request.
- The service was designed to facilitate patient flow respecting patient privacy and dignity. Facilities included private assessment and consultation rooms and a patient waiting area. The service was accessible by public transport and car parking was available.

Access and flow

- Patient appointments and booking were managed jointly between surgery and outpatients. For our detailed findings please see the Safe section in the surgery report.
- Patients could choose the consultant they wanted for their surgery and were seen by the same consultant each time, ensuring continuity of care.
- Patients told us appointments were flexible to fit in with personal commitments.
- The provider routinely monitored performance in areas such as patient wait times, consultation to treatment times. This was combined across both OYEH and Optegra Leeds.
- Across OYEH, all patients waited an average of 3.9 weeks from referral to first appointment and five weeks from consultation to surgery. This meant people waited an average of eight weeks from referral to treatment. Overall, 32% of all private patients at OYEH were seen within ten days, 34% within 3 weeks and 77% within a month.
- Across OYEH, NHS patients waited an average of 4.7 weeks from referral to first appointment and 4.9 weeks from consultation to surgery. This meant people waited an average of 7.7 weeks from referral to treatment. Overall, 11% of all NHS patients at OYEH were seen within ten days, 34% within 3 weeks and 63% within a month. 37% waited more than one month.
- The time needed for each outpatient appointment type was defined in the outpatient staffing protocol and the electronic patient appointment system scheduled appointments clustered appointments, so as to make efficient use of time.
- The appointment booking system did not include time allocated for exceptions during the schedule for the day, although we saw extra appointments could be allocated on the day, for example if a patient presented with an urgent problem.
- Staff told us some clinics were more likely to consist of patients who require more time for staff to assist them during appointments, perhaps due to age or disability. Staff told us these clinics felt pressured as the additional time needed to meet individual needs was not taken into account in the scheduling process.
- Staff told us appointment allocation for biometry and pre-assessment appointments had been a problem, meaning that sometimes patient had to wait or come back to the department on another day to complete their pre-assessment. We saw four incidents had been reported on this topic. Managers told us an appointment type and room schedule had been developed to allocate time for biometry in addition to pre-assessment, to address this.
- Optegra's UK weekly survey did ask patients if they had experienced any delays. Results showed 84% patients said they were seen on time, across Optegra as a whole (Nov 2017). Across Optegra, of those patients who experienced a delay, 63% waited 30 minutes or less, 87% waited less than an hour and 78% said they had received a satisfactory explanation.
- The hospital had received one informal complaint about delays during the three months and two of the eight patient comment cards we received at OYEH related to waiting times in the department, for example one patient said there was; 'a long delay second time' and another stated; 'long delay. No communication by staff as to how long delay will be.'
- The hospital quality accounts identified wait times in the department as an area for development, although outpatient clinic wait times (from arrival to being seen) were not monitored at the time of inspection.
- Managers told us it was not possible to retrieve information on the number of cancellations or patients that did not attend appointments, using the patient information system. However, managers told us no cancellations of outpatient appointments had been reported via the incident reporting system and Optegra UK was looking into the system data issue.
- Letters were prepared and printed on the day of the appointment to send out to patients' GPs. There had been one incident where a GP letter had not been sent out in a timely way, which meant the patient's GP did not know what to prescribe when patient needed more eye drops. Managers told us the timeliness of sending GP letters was not monitored.

Good

Outpatients and diagnostic imaging

Meeting people's individual needs

- Staff told us it was important to take time to assess individual patient needs, especially where they acted as barriers in accessing services, for example related to sight problems, age or disability. Staff described examples where appointments had to be extended and where reassurance and support given to enable patients to complete tests or assessments.
- We saw the outpatient waiting area was comfortable and hot drinks, water, snacks were available free of charge. Magazines and information leaflets were available. There was sufficient space for wheel-chair users and a lift was available. A quiet, private space for prayer could be made available on request.
- Although the hospital told us signage had been designed to meet RNIB accessibility guidelines, we did not see high contrast signage and we did not see patient information readily available in different formats e.g. large print. The availability of information in formats to meet the needs of people with impaired sight would benefit patients in their understanding and involvement of the treatment they are to receive. Providing information in easy to read format and reasonable adjustments is best practice in line with Royal College of Ophthalmology guidance (2017). Optegra's consent policy also states written information will; 'be available in large print / different languages'.
- Most staff we spoke with knew who to contact to arrange a face to face or telephone interpreter to assist a patient with English as a second or other language although none had used the interpreting service. Some staff told us they thought patients were advised to bring their own interpreter or a family member. Some written patient information could be made available in other languages on request. Managers told us a British Sign Language interpreter could be obtained and that no charge would be made to a patient for any interpreting.
- Although there were no specific arrangements in place for providing a service to people with a learning disability, bariatric patients or nervous patients, staff told us that if a patient had any additional needs, they could be recorded in the pre assessment information and could be flagged on the electronic record system.
- For our detailed findings please see the Safe section in the surgery report.

Learning from complaints and concerns

- The hospital had received 15 complaints during the past 12 months and seven thank you letters. For our detailed findings please see the Safe section in the surgery report, as they were managed in the same way for outpatients and surgery.
- For our detailed findings please see the Safe section in the surgery report.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- The service was led by the hospital director who was also the registered manager and had been in post since March 2017. The hospital director was responsible for Optegra Yorkshire Eye Hospital, Optegra Leeds and Optegra Manchester Eye Hospital.
- Although the patient services manager post was vacant at the time of inspection, the service had appointed a new CSM, with responsibility for clinical skills and supervision of team leads.
- The theatre lead and diagnostic team leads who worked at both Optegra Leeds and Optegra Yorkshire Eye Hospital (OYEH) sites supported operational staff on a day to day basis and had covered some of the clinical services manager duties during the last 12 months.
- There was a clear leadership structure and a patient-focussed approach. The hospital director described the organisational culture as that of; 'an experienced, talented team, who were patient focussed, with a warmth applied to patient contact which embodies the organisation's values'. Optegra offered a 'colleague recognition scheme' to reward staff.
- The main themes from the annual OYEH staff satisfaction survey in February 2016 were access to IT and communications. There was a clear action plan in progress, including action to introduce the new daily 'huddle' meeting and include business updates at the whole hospital meeting, (which formed the main communication channels at the time of inspection), and work to improve internet access. A new staff survey was due in February 2017.

- Staff told us teamwork was good although leadership had been lacking for some months due to manager changes and vacancies. Although most staff told us leaders were approachable, one member of staff was very concerned about speaking with the CQC inspector when asked to comment on leadership. Staff we spoke with were familiar with their individual roles and responsibilities, although they told us manager vacancies had meant staff taking on more responsibility. Staff said communication had not been good in recent months, and clinical team meetings had not taken place.

Vision and strategy

- Optegra's vision was 'To ensure Optegra UK is a market leading profitable provider of first choice, famous for patient service and eye care excellence because we look after our colleagues, who look after our patients'.
- We saw the corporate values were available on the website and the vision and strategic plan were shared with staff at quarterly whole hospital meetings. Staff we spoke with understood the local vision and strategic plan.

Governance, risk management and quality measurement

- There were structures in place to maintain clinical governance and risk management. There was ongoing work to update policies and procedures. Performance data was collected and analysed and work was underway to develop a more robust system to identify themes and trends from different data sources.
- Optegra UK held clinical service managers (CSM) meetings and integrated governance steering group (IGSG) meetings every three months. These were attended by the corporate clinical lead and head of clinical governance and risk, together with CSM's and hospital directors from UK Optegra services.
- Key areas discussed were medicine management, infection control, safeguarding, clinical incidents and health and safety.
- The CSM meetings ensured commonality across the services, shared pathways, documentation and encouraged staff recognition of their relationship with the provider.
- The IGSG led corporate work to review and standardise patient pathways, update policies and improve the corporate governance framework and systems. For example, it was responsible for commissioning a new electronic corporate governance system, to bring together existing data on incidents, complaints and mandatory training compliance.
- The provider had introduced a local balanced scorecard that measured 'Key Performance' across all areas including colleague satisfaction, impact on patients, processes and financial performance. This incorporated eleven metrics and was benchmarked monthly against best practice.
- Weekly operational review calls and monthly Operations Meetings were held across Optegra's seven hospitals to share insight and benchmark across all hospitals.
- A governance structure was in place to ensure information and learning was cascaded up to the provider's board. Audits were conducted in line with national standards. Actions fed into the Yorkshire action plan and were monitored at the IG meetings.
- The outputs from the hospital integrated governance meeting were reviewed to ensure consistency, monitor trends and adherence to policy and outcomes data, complaints and serious incidents were also reviewed. We saw evidence of this by reviewing the minutes from the last three OYEH integrated governance (IG) meetings.
- Surgical outcomes were collated by the provider's Eye Sciences division and shared with the hospital director. They were discussed and reviewed at the MAC, with individual consultants, and at the corporate Governance Committee on a Quarterly basis.
- Quality clinical reports were discussed at the local IG meeting and the local MAC – agenda items included incidents, never events, SUIs, returns to theatre, unplanned outpatients, transfers and duty of candour.
- There was a 'strategic risk register' in place for OYEH, including Leeds. The risk register accurately reflected risks within the hospital and was reviewed via integrated governance meetings. The risk register described the cause and consequence of each risk. The type of risks were categorised as financial, quality or operational and risks could be added to the register as a result of incidents.
- The MAC met quarterly and was attended by the chair, an optometrist, clinical nurse, consultant and a spread of sub-specialities from other parts of OYEH for glaucoma, refractive eye surgery, cataract, cornea and retinal. Safety, adverse events, infections, complaints

and incidents were discussed and learning taken from critical incidents and events. Potential new procedures were also discussed at the MAC and had to be signed off by the medical director as safe.

- Optegra's governance structure identifies monthly team meetings (clinical team and patient services team) as the key route for sharing learning e.g. from incidents, complaints and changes in practice and policies. However, team meetings had not been consistent in recent months due to vacancies in the management team. The daily 'huddle' meeting and whole hospital meeting were the main routes for staff updates. Staff we spoke with were aware of an ongoing project to update policies and procedures and received updated policies circulated to staff via email following the huddle.

Public and staff engagement

- The hospital had a website where full information could be obtained about the treatments available for patients. It was very comprehensive including information about costs and finance.
- Patient views were sought in a number of ways, e.g. electronically, survey, comment books and a friends and family test. The patient experience survey (2016/2017) showed 97% of patients would recommend the hospital to family and friends (81% highly likely to recommend).
- Patient comment cards were positive and described the service as; 'clean, nice staff, friendly welcome'; 'good all round treatment and service' and staff were; 'extremely helpful staff, relaxed atmosphere, everything explained in full'.
- Regular refractive (laser) surgery open evenings were held at OYEH where consultants gave a presentation and discussed the various treatments on offer. Potential patients could meet prospective consultants, receive procedure information, ask questions and tour the hospital.
- The Eye Sciences division had developed a patient questionnaire for those who had undergone cataract surgery, laser vision correction or refractive lens exchange. The questionnaire was developed to be delivered by a touch screen tablet or a paper version was also available.
- A patient forum was not in place at the service. Patient forums are usually open to any patient or relative to discuss any concerns or anxieties they may have about the hospital and treatment.
- The hospital developed an action plan (March 2017) from the results of the 2016 staff engagement survey. This highlighted a number of issues about clarity on targets and progress, information technology, job satisfaction, infrastructure, communication between teams and staff shortages. The action plan identified outputs for each action and identified accountability and timescales. For example a daily bulletin and daily staff huddle meetings were introduced to improved communication between teams; IT access was improved to reduce problems in accessing records, and; recruitment of key management roles – the CSM and PSM was progressing. A planning meeting and regular clinical team meetings were to be introduced from November 2017.
- Staff huddles took place daily at 10am where staff were informed of who the theatre lead was for the day, anticipated visitors to the service, roles and responsibilities of staff and other relevant information that needed sharing.
- The provider ran a staff recognition scheme where staff could nominate individuals and teams.

Innovation improvement and sustainability

- There was innovation in monitoring clinical data and the service had commissioned a new integrated clinical governance system.
- Optegra UK Eye Sciences division manages the collection and reporting of clinical data for all 7 UK locations. This team also audit Optegra services provided outside the UK, which included Poland, Czech Republic, China and Germany. The data covers clinical complications, visual and refractive outcomes for laser, lens replacement and cataract patients, to an agreed protocol. Data is captured using an electronic patient record (EPR) system.
- This work meant performance and patient outcomes at each service could not only be benchmarked with the seven UK locations, but across a wider sample, internationally. Managers told us bi-weekly calls were held to share information nationally and contribute to continuous improvement and performance across the group.
- Managers told us a new electronic system, to co-ordinate reporting and learning from incidents,

mandatory training and alerts was piloted in November 2017. We were also told that this system would be fully introduced in January 2018 to provide a more robust approach to corporate governance.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should include reference to the licensing authority for medicines in the UK in the patient consent forms explaining the off-licence use of cytotoxic medicines.
- The provider should take actions to ensure medicines are stored securely in the outpatient's area.
- The provider should consider monitoring outpatient clinic wait times (from arrival to being seen) and the number of patients who do not attend appointments, in order to improve services.
- The provider should include reference to the licensing authority for medicines in the UK in the patient consent forms explaining the off-licence
- The provider should consider making available patient information materials in different formats, such as large print that would be useful for patients with impaired sight.
- The provider should submit data to the Private Healthcare Information Network (PHIN) in accordance with legal requirements regulated by the Competition Markets Authority (CMA).