# SpaMedica - Wakefield

## Quality Report

Unit 10
Silkwood Park
Wakefield
West Yorkshire
WF5 9AD
Tel: 0330 058 4280
Website: www.https://www.spamedica.co.uk/

Date of inspection visit: 23 January 2019
Date of publication: 08/04/2019

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

## Ratings

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

### Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

# Summary of findings

## Letter from the Chief Inspector of Hospitals

SpaMedica Wakefield was operated by SpaMedica Limited. Facilities include an operating theatre, and outpatient's department.

We inspected using our comprehensive inspection methodology. The unannounced inspection (people did not know we were coming) took place on 23 January 2019.

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

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

The main service provided was surgery.

**Services we rate**

This was the first time we had inspected this service. We rated it as **Good** overall.

We found good practice in relation to surgery:

Mandatory training compliance was positive. Staff understood how to protect patients from abuse. Infection prevention and control was managed well, the environment was clean and equipment was safely maintained. Staff completed risk assessments for each patient. The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Staff kept records of patients' care and treatment securely. The service followed best practice when prescribing, giving, recording and storing medicines. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

The service provided care and treatment based on evidence based national best practice guidance. Staff assessed and monitored patients regularly to see if they were in pain. Managers monitored the effectiveness of care and treatment. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support. Staff of different kinds worked together as a team to benefit patients. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw staff seeking patients consent before providing care and treatment.

Staff cared for patients with compassion. Feedback from patients consistently confirmed that staff treated them well and with kindness. Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.

The service planned and provided services in a way that met the needs of local people and took account of patients' individual needs. People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. The service had a vision for what it wanted to achieve and plans to turn it into action. The company promoted a positive culture that supported and valued staff. The service improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish. The service had good systems to identify risks, plans to eliminate or reduce them, and cope with both the expected and unexpected. The service collected, analysed,

# Summary of findings

managed and used information well to support all its activities, using secure electronic systems with security safeguards. The service engaged well with patients, staff, the public and local organisations to plan and manage services. The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

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

**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 service. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.<br>We rated this service as good because it was safe, caring, responsive and well led. We rated effective as outstanding. |

# Summary of findings

## Contents


### Summary of this inspection

Page

Background to SpaMedica - Wakefield 7

Our inspection team 7

How we carried out this inspection 7

Information about SpaMedica - Wakefield 7

The five questions we ask about services and what we found 9

### Detailed findings from this inspection

Overview of ratings 12

Outstanding practice 27

Areas for improvement 27

Good

# SpaMedica Wakefield

**Services we looked at:**
Surgery

# Summary of this inspection

## Background to SpaMedica - Wakefield

SpaMedica Wakefield was operated by SpaMedica Limited. The service opened in 2016. It was a private clinic in Wakefield, West Yorkshire. The clinic primarily served the communities of the Wakefield and the surrounding areas of West Yorkshire offering cataract surgery and yttrium-aluminium-garnet laser (YAG) capsulotomy services for NHS patients (YAG capsulotomy is a special laser treatment used to improve your vision after cataract surgery). They also accepted patient referrals from outside this area.

The service has had a registered manager in post since February 2017.

## Our inspection team

The team that inspected the service comprised of a CQC lead inspector and a specialist advisor with expertise in Ophthalmology. A member of the CQC analyst team also attended to shadow the inspection for development purposes. The inspection team was overseen by Sandra Sutton, Inspection Manager and Sarah Dronsfield, Head of Hospital Inspection.

## How we carried out this inspection

We inspected using our comprehensive inspection methodology. The unannounced inspection (people did not know we were coming) took place on 23 January 2019.

## Information about SpaMedica - Wakefield

The service had two floors. The ground floor had an operating suite, with one theatre providing cataract surgery, which was the main service provided. The first floor housed the outpatient department, where pre and post-operative assessments were provided. The service did not treat children.

The service was registered to provide the following regulated activities:

- Diagnostic and screening procedures.
- Surgical procedures.
- Transport services, triage and medical advice provided remotely.
- Treatment of disease, disorder or injury.

During the inspection, we visited the theatre suite and outpatient's departments. We spoke with 14 staff including registered nurses, health care technicians, reception and administration staff, medical staff, operating department practitioners, and senior managers. We spoke with nine patients. We did not inspect the transport service provided by SpaMedica Limited at this location.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service had not been inspected before.

Activity (01 November 2017 to 31 October 2018).

- Information provided prior to our inspection showed the service had received 5097 cataract surgery referrals and 1137 referrals for YAG laser from 01 November 2017 to 31 October 2018.

# Summary of this inspection

- Referral to treatment (RTT) data showed 38% of patients were treated within four weeks and 99% of patients were seen within 18 weeks in July 2018. In August 2018, 29% of patients were seen within four weeks and 99% were seen within 18 weeks.

There were four ophthalmic surgeons working in the service under practising privileges. Other SpaMedica employees included optometrists, administration staff, six registered nurses, five healthcare technicians and three operating department practitioners.

Track record on safety:

- There had been no never events in the previous 12 months.
- The service reported 47 incidents from December 2017 to December 2018. Of these, 37 were reported as no harm, seven were low harm, two were moderate harm and one was severe harm. There were no deaths reported.
- There had been no incidences of Methicillin-resistant Staphylococcus aureus (MRSA) reported by the service in the last 12 months.
- There had been no incidences of Methicillin-sensitive staphylococcus aureus (MSSA) reported by the service in the last 12 months.
- There had been no incidences of Clostridium difficile (c.diff) reported by the service in the last 12 months.
- There had been no incidences of E-Coli reported by the service in the last 12 months.
- The service had received nine complaints from October 2017 to September 2018.

Services under service level agreement included:

- Clinical and or non-clinical waste removal.
- Interpreting services.
- Grounds Maintenance.
- Laundry.
- Maintenance of medical 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

This was the first time we had inspected this service. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse, they had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept records of patients' care and treatment securely.
- The service followed best practice when prescribing, giving, recording and storing medicines.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and managers used this to improve the service.

However, we also found:

- Sterile equipment was not always stored in appropriately designated areas.

### Are services effective?

Outstanding

This was the first time we had inspected this service We rated it as **Outstanding** because:

- The service provided care and treatment based on evidence based national best practice guidance.
- Staff assessed and monitored patients regularly to see if they were comfortable and to ensure they were not in pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other national services to learn from them.

# Summary of this inspection

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service provided documented health promotion literature to all patients.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw staff seeking patients consent before providing care and treatment.

## Are services caring?

Good

This was the first time we had inspected this service. We rated it as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

## Are services responsive?

Good

This was the first time we had inspected this service. We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of local people.
- The service had optometrists who were accredited to provide post-operative care. Patients could choose to have their post-operative follow up with one of these services if it was more convenient.
- Patients were given a choice of appointments to suit their social needs and emergency appointments were available each day.
- Patients had access to a 24-hour seven day on call service for any post-operative concerns.
- The service took account of patients' individual needs.
- The service had access to an independent translation and interpreter service. Patient booklets were also available in different languages.
- The service had ten dedicated dementia champions available to support patients living with dementia.

# Summary of this inspection

- Referral to treatment times were much better than the England average.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However, we also found:

- Some staff told us family members would be used as interpreters. NHS England advocate patients should always be offered a registered interpreter. The use of family, friends or unqualified interpreters is strongly discouraged in national and international guidance and is not considered to be good practice.

## Are services well-led?

Good

This was the first time we had inspected this service. We rated it as **Good** because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service had good systems to identify risks, plans to eliminate or reduce them, and to cope with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Surgery | Good | ☆ Outstanding | Good | Good | Good | Good |
| Overall | Good | ☆ Outstanding | Good | Good | Good | Good |

Good

# Surgery

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

## Are surgery services safe?

Good

This was the first time we had inspected this service. We rated it as **good.**

### Mandatory training

- Staff completed a mixture of face to face and e learning modules. All staff completed the e learning modules which included equality, diversity and human rights, health, safety and welfare, conflict resolution, fire safety, infection control (level two), moving and handling (level two), safeguarding vulnerable adults level one, safeguarding children (level two), basic life support (level two) and information governance.
- Staff also completed role specific training, for example the registered manager completed level three safeguarding adults and children's training, all clinical staff completed safeguarding adults level two training, and all staff completed prevent and mental capacity act training.
- At the time of our inspection overall compliance for all subjects was between 83% and 100%. The figures included new members of staff who were in the process of completing the training and a member of staff who was on maternity leave which accounted for the levels below 100%.
- All staff completed life support training as part of their mandatory training requirements.
  - Optometrists completed intermediate life support: at the time of our inspection compliance was 100%.
  - Registered nurses and operating department practitioners completed advanced life support: at the time of our inspection compliance was 91%.
  - Heath care technicians completed basic life support: at the time of our inspection compliance was 83%. One member of staff was on maternity leave.
- The service had a training coordinator who monitored staff compliance with mandatory training. Most training was completed electronically. Once completed staff sent a copy of their certificates to the training coordinator to be logged on a central database.
- All staff we spoke with told us they were supported to complete training and were up to date with their mandatory training.

### Safeguarding

- The registered manager was the location lead for any safeguarding concerns, for adults or children. This member of staff completed face to face level three safeguarding adults training which was in line with inter collegiate guidance.
- Children were not treated in the service however all staff completed a level two adult and level two children's safeguarding e learning package.
- There was a safeguarding policy to support staff when dealing with any safeguarding concerns. This policy was in date, had appropriate references and gave staff the details of the local authority safeguarding teams for referral or advice.
- Safeguarding information, including the policies and contact telephone numbers were discussed at team meetings.

- There had not been any referrals made from the service in the previous twelve months. However, staff we spoke with were able to give examples of when they would raise a concern. Staff were aware of the policies available to them.

**Cleanliness, infection control and hygiene**

- The service had an infection control policy, we reviewed this policy, found it was in date and contained appropriate guidance to support staff to maintain good infection prevention and control (IPC) processes.
- There had been no incidences of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli reported by the service in the last 12 months.
- Post-surgical infection rates for the service were better than the national average.
- All staff completed IPC training. At the time of our inspection compliance was 82% with 10% of staff working through the course and 7% on maternity leave.
- The service had an IPC lead registered nurse and a cleaning and decontamination lead who had undertaken additional training specific to their roles.
- Hand hygiene audits were completed in January, March, August and October 2018. On all occasions the service scored 100% compliance.
- During our inspection we observed staff washing their hands before providing care and treatment. Personal protective equipment, such as disposable gloves and aprons were available, staff used these appropriately and were compliant with 'bare below the elbows' guidance.
- Hand hygiene reminder posters were displayed throughout the clinical areas, hand washing sinks and sanitising gel was also readily available.
- Environmental audits of the clinical areas had been completed in January, March, August and October 2018. On all occasions the service scored 100% compliance.
- All areas we visited were visibly clean and well maintained.
- The service had service level agreements in place with external companies for cleaning, laundry services and for clinical and domestic waste management. The registered manager told us they had no concerns with these services.

**Environment and equipment**

- The service had disabled toilets, disabled access and wheelchairs available for patients who needed these facilities. Lifts were also available and flexible diagnostic equipment and chairs to allow ease of access if required.
- The service had one theatre suite. Patient areas included a pre-operative consulting room, a pre-operative waiting area, the theatre and a discharge consulting room.
- We were provided with a copy of the certificate (issued June 2018) for the theatre which showed the air flow had been tested in accordance with heating and ventilation systems health technical memorandum 03-01: specialised ventilation for healthcare premises and had passed.
- The service had a service level agreement with the local NHS trust for the sterilisation of theatre instruments and lens injectors. All other equipment was single use.
- The service had processes in place to ensure the traceability of lens implants. Each lens had three identity stickers. One was placed in the patient's records, one in the operations register held in the theatre and the third was placed in a lens replenishment folder to aid stock control.
- We had some concerns about some clinical equipment, lenses and single use sterile equipment were not stored in designated rooms. Most equipment was stored in a room which also housed the theatre ventilation system, a 'bank' of lenses were stored in the computer server room. We noted this room had loose and missing ceiling tiles. Following our inspection, we received confirmation from the registered manager that the equipment had been relocated.
- Audits of the resuscitation trolley were completed in January, March, August and October 2018. Compliance was between 80% and 100%.

Good

# Surgery

- We looked at the emergency resuscitation equipment and saw daily and weekly checks were fully completed. The registered manager told us this task was allocated to an individual member of staff each day to help maintain compliance. Notices were clearly displayed to indicate where the equipment was stored.
- We saw a set of laser safety local rules specific to the service to support staff and to ensure the safety of staff and patients using the YAG laser. This included the use of goggles and signage about laser safety. The door to the laser room was kept locked when the laser was in use to prevent anyone entering the room.
- It was mandatory that all clinical staff completed the core of knowledge laser safety training. At the time of our inspection compliance with this training was 84% with the reamining16% of staff booked to attend the course in April 2019.
- The registered manager was the named laser protection advisor and staff had access to an external laser protection supervisor. Some staff told us the chief executive was the laser protection supervisor however the registered manager confirmed the arrangement as being an external person with a substantive contract with the NHS.
- Electrical safety testing was completed by an external company. During our inspection we saw all electrical equipment had been tested for electrical safety 17 January 2019. We were also provided with a log which showed all equipment had passed the testing.
- All medical devices were purchased in August 2016 when the service opened. Information provided by the facilities manager indicated all equipment had been managed under a warranty agreement with the manufacturer until August 2018. For 2019 onwards, the company had established service level agreements with external companies for the ongoing service and maintenance. SpaMedica held a central asset register for all medical devices which was managed and updated by the facilities team.

**Assessing and responding to patient risk**

- All patients attended a pre-assessment to ensure they were suitable to be treated safely at SpaMedica. This included a couch test, if necessary, to ensure patients could tolerate lying flat for the required period of time in theatre.
- Pre-assessment also included patients being assessed for their risk of posterior capsule rupture (PCR). Any patient with a risk score greater than 8% were referred as a complex case to the SpaMedica Sheffield facility which was able to provide vitreo-retinal (VR) surgery. This was in line with the National Institute for Health and Care Excellence (NICE) guideline [NG77] Cataracts in adults: management (October 2017).
- Patients had biometry testing prior to surgery. The results of these were automatically uploaded to the electronic record keeping system and were immediately accessible to surgeons and optometrists.
- The service used the World Health Organisation (WHO) Surgical Safety Checklist, held a safety brief, ensured patients were appropriately marked for theatre and had adopted ‘stop before you block’ to ensure patients were safely managed. SpaMedica had developed a WHO Surgical Safety Checklist: for cataract surgery.
- The registered manager completed quarterly observational audits of compliance against the WHO checklist. We looked at the data for October 2018 which showed 100% compliance.
- The service had a health and safety policy to support staff to safely care for patients. However, this did not reference any appropriate legislation or best practice guidance and was out of date with a review date of November 2017.
- We discussed this with the registered manager at the time of our inspection who explained this was a corporate level concern. We were assured this policy was being reviewed and was due to be ratified within the next three months.
- Following our inspection, we were provided with minutes of the last two health and safety meetings which the registered manager for the service attended. These showed site specific incidents and health and safety concerns were discussed and actions to mitigate any risks were considered and shared as lessons learned.

- Health and safety was discussed at the clinical governance meetings. We saw that National Patient Safety Agency (NPSA) alerts were reviewed at the clinical governance committee. In the minutes we reviewed none of the most recent alerts were relevant to the service.
- Patients were given a post cataract surgery information leaflet which provided details of the services emergency 24-hour telephone help line and the general enquiries contact number.
- In the event of an emergency, such as a cardiac arrest or a patient fall with harm, staff would call 999 and the patient would be transferred to a local NHS hospital. SpaMedica Wakefield did not have a formal service level agreement with the local NHS hospitals for the transfer of patients.
- Most ophthalmic complications would be dealt with by SpaMedica. The service offered a 24 hour on call provision which included a consultant, two optometrists and nurses. Calls were triaged and if urgent, we were told the on-call team would open a SpaMedica service during the out of hours period.

**Nursing and support staffing**

- The service held a forecast meeting each Tuesday to plan nurse staffing for the clinics and operations.
- The outpatient department establishment was five WTE RN's and five WTE health care assistants.
- There were no vacancies at the time of our inspection. Staff we spoke with said they felt staffing levels were safe.
- From October 2017 to September 2018 HCA turnover was 7.1%. The service did not have a target for turnover. There was no reported turnover for any other staff groups.
- Information provided prior to our inspection showed the service employed one whole time equivalent (WTE) registered nurse (RN) for theatres and three WTE operating department practitioners.
- There were no vacancies at the time of our inspection. Staff we spoke with said they felt staffing levels were safe.
- From October 2017 to September 2018 HCA turnover was 7.1%. The service did not have a target for turnover. There was no reported turnover for any other staff groups.

**Medical staffing**

- The service held a forecast meeting each Tuesday to plan medical staffing for the clinics and operations.
- The service employed four consultant ophthalmologists under practising privileges. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services.
- The recruitment process included checks of current and past medical registration and any disciplinary proceedings or court judgements. This was followed by an interview and formal appraisal of surgical technique. Ophthalmologists were required to complete a formal application for practising privileges, which was submitted to and approved by the medical advisory committee.
- We looked at the recruitment checks for all four members of medical staff and found all had appropriate General Medical Council (GMC) registration on the specialist register. All had up to date revalidation recorded. All medical staff had completed more than 100 procedures in the last 12 months.

**Records**

- The service used a nationally recognised electronic record system to produce each set of care records. These records ensured that all relevant assessments, were completed in line with the guidelines from the Royal College of Anaesthetists and the Royal College of Ophthalmologists local anaesthesia for ophthalmic surgery (February 2012) and National Institute for Health and Care Excellence (NICE) guideline [NG77] (October 2017) Cataracts in adults: management. These were created centrally and prepopulated with patient demographics. Administration staff then printed these when patients were due to attend for pre-assessment and maintained at the service until the patient was discharged. Once a patient was discharged the records were moved to a central archive.

- The service undertook a quarterly documentation audit. This showed compliance of 86% in March 2018, 87% in June 2018, improving to 94% in September 2018.
- During our inspection we saw records were completed in full and stored securely.

**Medicines**

- The service had a medicines management policy to support staff. We were provided with this before our inspection, it was in date and contained appropriate guidance to support staff to safely manage medicines. The policy also had specific information for each site to ensure any staff working across sites were aware of these details.
- The Medicines and Healthcare Products Regulatory Agency (MHRA) regulates medicines, medical devices and blood components for transfusion in the UK. We saw the medicines policy gave advice about staff's responsibilities in relation to any alerts and how these should be managed.
- Medicine management was monitored by the clinical governance committee. We saw that MHRA alerts were discussed at the clinical governance meetings and where necessary disseminated to the service.
- Medicines were stored appropriately and securely.
- Monitoring of medicine fridge temperatures was audited in January, March, August and October 2018. Compliance was between 96 and 100%.
- We looked at the monitoring of fridge temperatures during our inspection and found these were fully completed. The registered manager told us this task was allocated to an individual member of staff each day to help maintain compliance.
- The service used patient specific directions (PSD's) to enable staff to administer medicines, such as eye drops, without a patient specific prescription. At the time of our inspection 89% of eligible staff had completed medicines management training. One RN (11%) was new in post.
- If patients needed any medicines outside the PSD's, staff had access to five prescribers within the company who were contactable via a group email. This meant the patient may need to wait until a prescriber responded to the request. We discussed this with the senior team who told us delays were minimal.
- Patients were given advice on how to administer post-surgery eye drops and also provided with a post cataract surgery booklet which included information about this and also a three-week timetable for patients to log administration of eye drops.

**Incidents**

- The service had introduced an electronic incident reporting system. Some staff were not yet using the system and were completing paper forms which were then inputted on to the system. The corporate team were sighted on this and training for all staff was being rolled out across the company.
- The service reported 47 incidents from December 2017 to December 2018. Of these, 37 were reported as no harm, seven were low harm, two were moderate harm and one was severe harm. There were no deaths reported.
- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- There were no reported never events from December 2017 to December 2018.
- Staff we spoke with were aware of their responsibility to report incidents and were able to give examples of incidents they would report.
- The service had incident reporting policies in place to support staff. We looked at the serious untoward incident policy and the policy for critical incident reporting and management. These policies were in date and contained references to, grading of incidents and appropriate agencies for reporting of incidents. For example, advice was given about when incidents were reportable to the coroner, local authority safeguarding team, medicines and healthcare products regulatory agency (MHRA) and the health and safety executive (HSE).

Good

# Surgery

- We saw incidents were discussed at the local team meetings and the clinical governance committee meetings. Lessons learned were shared locally and also cascaded to other locations for shared learning.
- Staff we spoke with were able to describe their responsibilities in relation to duty of candour, they described being open, transparent and apologising when things went wrong. We saw from the minutes of the clinical governance meetings that following a clinical incident or on receipt of a concern, either verbally or in writing, a senior member of staff contacted the patient to discuss their concerns and offered an apology and an explanation.

## Are surgery services effective?

Outstanding ☆

This was the first time we had inspected this service. We rated it as **outstanding.**

### Evidence-based care and treatment

- Care was provided in line with nationally recognised best practice guidelines, for example, the joint guidelines from the Royal College of Anaesthetists and the Royal College of Ophthalmologists local anaesthesia for ophthalmic surgery (February 2012) and National Institute for Health and Care Excellence (NICE) guideline [NG77] (October 2017) Cataracts in adults: management.
- Compliance with relevant guidelines was monitored through governance processes. We looked at the clinical governance meetings which showed revision and updating of policies was monitored through this committee.
- We looked at 15 policies and found the majority of these were in date and had references to national best practice guidance. However, we found the health and safety policy and the fire risk assessment were out of date for review. Although this was a corporate responsibility we asked about this and were told the company did not have a current overarching policy. However, the company had recently appointed a health and safety corporate lead. It was expected a revised policy would be available within three months. In the interim the health and safety committee had prioritised the revision of several procedures, for example the environmental and fire risk assessments. We were provided with updated copies of these which confirmed what we had been told.

### Nutrition and hydration

- The service provided free hot drinks and biscuits for relatives and patients who were waiting for surgery.
- The service had recently introduced the provision of gluten free biscuits.

### Pain relief

- The service collated pain and comfort during surgery data from patients through a questionnaire which was completed prior to patients leaving the service after discharge.
- The service used topical anaesthesia during surgery.
- During 2018, 99% of patients reported mild or no pain, 0.8% reported moderate and 0.2% said their pain was severe.
- Patients were provided with a leaflet which gave advice on expected post-surgery symptoms and pain management.

### Patient outcomes

- The service collated data to determine complications and outcomes of cataract surgery performed in SpaMedica Wakefield and to compare with national standards. The service submitted data for inclusion in the National Ophthalmic Database Audit (NODA).
- The service completed monthly audits of:
  - Vision loss of more than 3 lines.
  - Posterior capsule rupture (PCR) rate.
  - Refractive outcomes.
  - Vision outcome of 6/12 or better.
  - Patient reported outcomes including pain during surgery and comfort during surgery.
- Information provided by SpaMedica showed the overall PCR rate in 2017 as 0.5% which was better than the national average rate of 1.9%.
- Post-operative complication rates were as follows:

- Vision loss of more than three mines rate of 0.5% against a national average of 0.9%.
- A post-operative uveitis rate of 0.8% against a national average of 3.3%.
- A cystoid macular oedema rate of 1.1% against a national average of 1.6%.
- A raised intra ocular pressure rate of 0.3% against a national average of 2.6%.
- A corneal oedema rate of 2.6% against a national average of 5.2%.
- A retained soft lens matter rate of 0.07% against a national average of 0.45%.
- An intra ocular decentre rate of 0.21 against a national average of 0.22%.
- A retinal detachment rate of zero against a national average of 0.03%.
- An endophthalmitis rate of zero against a national average of 0.03%.

- This meant SpaMedica performance was better than the national average for all complication measures.
- In the 2018 National Ophthalmology Database (NOD) Audit, SpaMedica achieved 93% against the Royal College of Ophthalmologists standards for refractive outcome of 85% within one dioptre and 96% against a standard of 95% for vision outcome of 6/12 or better.
- The service also collated and reviewed quarterly comparative complication and infection rates for individual surgeons. We were told any issues would be addressed immediately with the relevant surgeon and were given an example of how this had been managed.
- Patient outcomes were monitored by the clinical governance committee.

**Competent staff**

- Spamedica had a dedicated central educational team who were responsible for monitoring compliance with mandatory training and also providing competency-based education sessions.
- We were told all staff attended a two-day induction to SpaMedica and all staff (including bank or agency) were assessed using competency training before they could work in any role.
- SpaMedica had been awarded a gold standard accreditation for Investors in People. Investors in People is a standard for people management, offering accreditation to organisations that adhere to the Investors in People Standard.
- Information provided prior to our inspection showed from October 2017 to September 2018 100% of all staff received an appraisal.
- Staff we spoke with told us they had an up to date appraisal and they found the process effective to highlight any developmental needs.
- Senior staff told us appraisals took place in May each year, with a six-monthly review around November.
- Routinely each surgeon was provided with 360-degree feedback twice a year. This type of feedback is a method of performance appraisal which gathers feedback from a number of sources, including peers, direct reports, more senior colleagues and customers.
- Any human resource issues were discussed and reported at the clinical governance committee meetings. This included recruitment, mandatory training and appraisal compliance.
- Prior to our inspection SpaMedica told us they had recently started a leadership development programme for registered managers.
- All staff completed additional competency training specific to their roles. We were provided with copies of the competency training details. Competency training was coordinated by the training lead, who also kept a central log of completed training and when staff required updates.
- The registered manager was the named laser protection advisor and staff had access to an external laser protection supervisor. Some staff told us the chief executive was the laser protection supervisor however the registered manager confirmed the arrangement as being an external person with a substantive contract with the NHS.

Good

# Surgery

- We were told accreditation evenings were held for community optometrists. It was a requirement for any optometrists wishing to join the service to attend the presentation and pass a test before they could register with SpaMedica to carry out post-op follow up checks on SpaMedica patients.
- All staff completed additional competency training specific to their roles. We were provided with copies of the competency training details. Competency training was coordinated by the training lead, who also kept a central log of completed training and when staff required updates.

**Multidisciplinary working**

- All staff we spoke with told us different members of the team worked well together. This included medical, nursing, health care technicians, administrators and optometrists.
- The service liaised with external providers such as the patients G.P, the local NHS trust and opticians.
- SpaMedica limited was also working with eye charities and had delivered eye health promotion in schools. The medical director was keen to benchmark with other services to further improve the services offered to patients.

**Seven-day services**

- The service offered a 24-hour, seven day on-call service for patients, with phone calls triaged by nurses and optometrists.

**Health promotion**

- Health promotion information was included within documented information provided to patients. This included information about when patients could drive or operate machinery, return to work, drinking alcohol post-surgery, flying, exercise, gardening, sport and also about personal hygiene and wearing make-up for female patients.
- SpaMedica was working with clinical commissioning groups and local charities to support a project within schools promoting eye health.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- We looked at the mental capacity act (MCA) policy and consent policy for the service, these were in date and included references to appropriate legislation and guidance.
- All staff completed MCA training as part of their mandatory e learning package. This training covered what the MCA was and who was affected by it, the five principles of the act, the two-stage test for assessing capacity, the role of the mental capacity advocate, the court of protection and lasting power of attorney and also the deprivation of liberty safeguards.
- We saw staff seeking consent prior to providing any care and treatment. The service had documents available in large print for patients who were visually impaired.
- The service used a two-stage consent process. This including an initial consent being taken at the pre-assessment stage and a second stage by the consultant on the day of surgery.

## Are surgery services caring?

Good

This was the first time we had inspected this service. We rated it as **good.**

**Compassionate care**

- We observed staff providing compassionate care and treatment. Without exception, we saw staff behaved in a professional manner and were polite, friendly, caring and compassionate to patients and their family members.
- We spoke with patients at the time of our inspection and contacted some by telephone, with their consent after the visit. Patients described the staff as 'brilliant, caring and delightful'.
- One person said nothing was too much trouble for the staff and they had found everyone, from the reception staff to the consultant 'amazing'. Some said the service ran like clockwork, three said they had a long wait for their surgery but staff kept them informed about the timings.

Good

# Surgery

- The service used a patient questionnaire at discharge. This included questions about the comfort, the surgeon's manner and the patient's general happiness with the way they had been treated by all staff.
- During 2018, 97.8% reported being very comfortable during their surgery and 2% said they were moderately comfortable, 98% of patients reported the surgeons as having a good bedside manner, 1.7% reported this as acceptable.
- The service had a chaperone policy and information was displayed to advise patients that chaperones were available.

**Emotional support**

- Private rooms were available for confidential discussions, and we observed staff supporting patients emotionally. They asked if patients had any questions and allowed time for this.
- Patients told us if they were nervous staff had been patient and had explained everything to them.
- In the 2018 staff survey, 97% of staff said they felt the work SpaMedica did had a positive impact on people's lives.

**Understanding and involvement of patients and those close to them**

- We saw staff discussing patients care with them in a way they could understand and patient's relatives were able to stay with them for support until they went in to theatre.
- One member of staff in the theatre was always available to stay at the patient's side to support them and explain what was happening.
- Patients told us they had been able to choose appointments which suited them. When they needed to cancel or rearrange an appointment staff were helpful and made them feel at ease.

## Are surgery services responsive?

Good

This was the first time we had inspected this service. We rated it as **good.**

**Service delivery to meet the needs of local people**

- The service operated from 9am to 5pm Monday to Friday and routinely ran lists of 25 patients. Surgical lists were also arranged on Saturdays depending on demand.
- Referrals, clinics and theatre lists were arranged centrally and sent out to each service every four weeks in advance. Patients were booked for their pre-assessment centrally. Surgery and post-operative checks were arranged at the service following pre-assessment.
- The service had optometrists who were accredited to provide post-operative care. Patients could choose to have their post-operative follow up with one of these services if it was more convenient.
- The service held a forecast meeting each Tuesday to plan staffing for the clinics and operations.
- Patients were given a choice of appointments to suit their social needs and emergency appointments were available each day. A staff member told us patients usually waited two to three weeks for an appointment, and patients we spoke with confirmed this.
- Patients had access to a 24-hour seven day on call service for any post-operative concerns.

**Meeting people's individual needs**

- Free tea, coffee, biscuits and water was provided for patients and their relatives. Wall mounted televisions were available in waiting rooms providing entertainment whilst patients waited.
- The service had an equality and diversity policy in place, this policy was in date and had appropriate guidance for staff to ensure all patients received equitable treatment regardless of their race, religion, gender, marital status, sexual orientation, disability, offending past, caring responsibilities, social class or age.
- The service had access to an independent translation and interpreter service. Patient booklets were also available in different languages. However, some staff told us family members would be used as interpreters. NHS England advocate patients should always be

offered a registered interpreter. The use of family, friends or unqualified interpreters is strongly discouraged in national and international guidance and is not considered to be good practice.

- A hearing loop was available for patients with hearing difficulties. This facility was clearly displayed at the service.
- The service had ten dedicated dementia champions available to support patients living with dementia.
- The service provided all patients with a post cataract surgery information booklet, this included information about after care including do's and don'ts. This was available in large print however the service had recognised that it needed to increase the font size and this was being produced by the company's marketing department.

**Access and flow**

- Appointment waiting times and referral to treatment performance data was monitored through the clinical governance committee meetings.
- Information provided prior to our inspection showed the service had received 5097 cataract surgery referrals and 1137 referrals for YAG laser from 01 November 2017 to 31 October 2018.
- Data we received prior to our inspection showed 38% of patients were treated within four weeks and 99% of patients were treated within 18 weeks in July 2018. In August 2018, 29% of patients were seen within four weeks and 99% were seen within 18 weeks.
- The service monitored the numbers of patients who were transferred out and these were reported through the clinical governance meetings. The reasons for the transfers were monitored through the minutes.
- The service monitored the numbers of cancelled procedures. We looked the data for October 2017 to September 2018 and found a total of 138 procedures had been cancelled as follows:
  - 93 (1.7%) patients cancelled due to contraindication – cataract theatre.
  - Six (0.1%) patients cancelled due to patient's decision – cataract theatre.
  - 16 (0.3%) patients cancelled due to provider reason – cataract theatre.
  - 19 (0.3%) patients cancelled due to other reason – cataract theatre.
  - Four (0.3%) patients cancelled due to other reason – YAG theatre.
- We asked staff about the reasons for non-clinical cancellations and were told these would only happen if there was short notice sickness which could not be covered or equipment failure. We were told any cancelled appointments were rescheduled as a priority.

**Learning from complaints and concerns**

- The company had a policy to support staff when dealing with complaints. We saw this policy was in date and had been developed using the NHS complaints handling guidance.
- We were told formal complaints were handled through the incident reporting system and timely investigation and feedback took place. All complaints were discussed at the clinical governance committee meetings. Lessons learned were shared locally and also cascaded to other locations for shared learning.
- The service actively encouraged informal feedback and comments, for example adding the date of printing to all patient letters in response to patient feedback.
- The service had received nine complaints from October 2017 to September 2018. We looked at three of these and saw all aspects of the follow up was logged on the electronic reporting system including the outcome. All complaints were signed off by a member of the senior management team.
- Information about how to make a complaint was included in the post-surgery information booklet. We also saw information displayed during our inspection.

## Are surgery services well-led?

Good

This was the first time we had inspected this service. We rated it as **good.**

**Leadership**

Good

# Surgery

- We met with the registered manager for the location who was friendly, approachable and had the right skills to lead the service. Staff at the service and the company leadership team confirmed this.
- Staff at the service, for example the registered manager and the administration lead, told us their immediate managers, who were not based at the same location, were also visible, approachable and supportive.
- Spamedica had a chief executive (CEO). Staff we spoke with were aware of who the CEO was and told us they received update emails from him.
- Due to the growth of the business the company had also recruited their regional clinical leads (area managers) and a chief operations officer (COO) to support all locations, in addition to a registered manager for each site.

**Vision and strategy**

- In the 2018 staff survey, 80% of staff reported they understood SpaMedica's vision and strategic objectives. These were defined as delivering a world class service to patients, operating safely and effectively, operating efficiently and in compliance with legislation, being the employer of choice within ophthalmology, supporting transformation to deliver care closer to home and safety, with integrity, kindness and transparency.
- SpaMedica services had grown from 8,402 cases in 2015 to 25000 in 2018.
- Staff we spoke with were aware of the company vision and values.
- The senior team explained they had completed capacity and demand scoping to ensure the services were made available in the most appropriate areas.

**Culture**

- We were told the company board of directors encouraged a culture of openness and transparency. We saw this reflected in the staff we met at our inspection. In the 2018 staff survey 83% of staff reported they shared the same values.
- Staff we spoke with told us they enjoyed working for the company. We were told the training and development budget had increased to meet the needs of staff and saw evidence of the projected increase from 2018 to 2019.
- One member of staff described the culture and team as 'fantastic.'
- We were told the company focused on a 'family-based culture' and staff said they felt supported, listened to and valued by the company.
- The company had a whistle blowing and raising concerns policy. We looked at this policy and saw it was in date. It contained reference to the Care Quality Commission as the most appropriate regulatory body for staff to raise concerns.
- The service had an equality and diversity policy in place. This policy was in date and had appropriate guidance for staff to ensure they were treated fairly regardless of their race, religion, gender, marital status, sexual orientation, disability, offending past, caring responsibilities, social class or age.
- Senior leaders told us, and we were provided with a copy of the certificate to show, SpaMedica had been awarded a gold standard accreditation for Investors in People. Investors in People is a standard for people management, offering accreditation to organisations that adhere to the Investors in People Standard. Developments by SpaMedica had included the introduction of a bonus scheme for staff, extended training and development opportunities, social events, salary banding in line with the NHS and bi-annual appraisals.

**Governance**

- Governance arrangements had been proactively reviewed by the corporate senior management team and improved processes had been implemented to ensure oversight of the companies risks and performance against a range of key performance indicators. This was mirrored at the location.
- SpaMedica had a clinical governance policy, which was in date, and a clinical governance committee, the purpose of the committee was documented within the policy as being to ensure:

- There was a continual focus on delivering the highest standards of quality patient care within the available resources.
- The components of clinical governance as identified by the CQC are addressed.
- A culture of continual improvement, professional learning and the sharing of best practice across all disciplines was maintained.

- The registered manager explained that they attended a weekly 'board report' meeting and the information from this was disseminated to staff at the location. The service reported to a quarterly governance group. Minutes were disseminated through staff meetings, where lessons learned and actions were discussed.
- In April 2018, SpaMedica introduced a monthly multidisciplinary clinical effectiveness group. The registered manager for the location attended this. We were told the aim of this was to ensure clinical governance was maintained through an integrated governance approach. At this meeting all areas of clinical practice were discussed, signed off and cascaded.
- We looked at the team meeting minutes from August 2018 and noted these included 'cascading from clinical governance' however there were no key points about what had been cascaded. This meant staff who were unable to attend the meeting would not be aware of these details. The team meeting minutes from November 2018 did not have any governance feedback. We spoke with the senior staff at the service who explained that staff were sent the minutes by email and asked to contact a member of the senior team for clarification if needed.

**Managing risks, issues and performance**

- The senior leadership team had improved how it identified and mitigated against risks, managed performance and identified issues with the introduction of an electronic reporting system.
- Spamedica had introduced a quality assurance and risk manager, part of this role involved supporting clinical teams to improve the focus and impact of the audit programme.
- We were informed that quality and effectiveness of processes for individual surgeons and by site were monitored. The service used the complication and infection rate audit results of all patients and analysed the results by surgeon and by site on a quarterly basis. The results were interpreted by SpaMedica associate medical director and discussed at the bi-monthly clinical governance meetings. They were also reviewed by the board and discussed at the bi-annual surgeon's meetings, with any relevant learning or changes in procedures clarified.
- The company collated patient outcomes and submitted data to national audit to benchmark their performance against other service providers. The data provided showed that they met or exceeded the performance targets for all indicators. In addition, the senior team planned services and used resources effectively to ensure they met referral to treatment times which were much better than the national average.
- Prior to the inspection we were told Spamedica operated a 'board to ward' communication ethos with meetings designed to create a two-way communication method. This included:
  - A daily onsite 'huddle' for all the clinical team, led by the clinical team leader or registered manager.
  - Monthly operations team meetings, with all registered managers and clinical team leaders, supported by the area managers and key headquarter managers. Information from the operational meeting was cascaded to staff at the monthly team meeting.
  - The bi-monthly clinical effectiveness group was the working 'operational governance' group. Monthly performance figures, new incidents and complaints were reviewed and discussed at this meeting, as well as discussing proposed innovations to the patient pathway.
  - A bi-monthly clinical governance group, which was used to consider themes from incidents and complaints and to share learning throughout the organisation.
- The senior team provided us with a power point presentation on the day of our inspection. This featured the processes undertaken to provide assurance of each

surgeon's performance. All surgeons were rated red, amber or green (RAG rated) every three months. The rating was provided by measuring clinical performance including complication rates and patient feedback. Where issues were identified these were highlighted with the relevant clinician and support provided, for example, surgical mentorship, to enable improvements.

- SpaMedica had a health and safety risk committee, which met monthly to ensure ongoing actions were completed in a timely manner and to embed routine risk assessments and ownership of risk registers at site level.
- Each location had its own risk register on the electronic reporting system. We looked at the one for Wakefield and saw this had actual and potential risks, a risk rating from low (no action required) to extreme (immediate mitigation required to remove or reduce the risk). We saw each risk was rated with actions to mitigate and indication of actions to ensure the risk could be tolerated with actions in place. Due to the risk registers being added to the electronic system, we did not see any updates or review of the risks but understood these would be completed by the registered manager.
- We looked at the fire risk assessment policy which was provided prior to our inspection. This was a corporate document. We found this was out of date for review (review date March 2016). The policy was not site specific but gave general advice on fire safety and minimising risk. Following our inspection, we were provided with an updated fire risk assessment which was location specific and had been completed in December 2018.
- Prior to our inspection we were provided with a copy of the business continuity plan for the service. We reviewed this and found it contained contact details for the services utility companies, equipment providers and their local support network, for example the local acute hospital. The policy also gave staff advice on how to manage any threat which may affect their ability to maintain services.
- SpaMedica had introduced a medical advisory committee (MAC) during 2018. A MAC is a group of health professionals whose role is to advise on medical matters, including proposed policies and action plans related to safe practices, patient management and whether to adopt new medical technologies.

**Managing information**

- Spamedica had introduced a corporate information security group. This was chaired by the CEO and supported by the Head of IT, COO and the Quality Assurance & Risk Manager. This group addressed all information governance issues.
- We were told SpaMedica had invested significantly in their IT infrastructure to improve the accessibility of patient records and the performance of the central contact centre and administration teams to support patient care. This had also included a staff intranet and development of their website to improve the resources and information available to staff and patients.
- Patients were provided with information about how their data may be used, anonymously, for audit and research processes.
- Patients were advised in writing calls to the service might be monitored and recorded.
- Administration staff we spoke with were able to describe the processes in place for maintaining patient's confidentiality. This include having 'log off' rules and privacy screens fitted to computer monitors.
- Staff completed information governance as part of their mandatory training. Compliance at the time of our inspection was between 83% and 100%. The figures included new members of staff who were in the process of completing the training and a member of staff who was on maternity leave which accounted for the levels below 100%.

**Engagement**

- We were told the company marketing team completed periodic patient focus groups. We were told the feedback provided had enabled SpaMedica to improve the patient pathway, approach and facilities.
- Patient satisfaction was reviewed at the clinical governance committee meetings.
- Staff satisfaction surveys were undertaken annually to gauge how the staff feel about the culture and

supportiveness of their managers. We were told that after receiving negative feedback in the 2017 staff questionnaire, the board had carried out roadshows, where they met staff at each site, listened to concerns and presented their planned changes for discussion. These had included structural changes and improvements to pay and benefits for staff at all levels.

- Staff we spoke with were positive about the senior team's engagement at local level. We also saw a monthly newsletter which was circulated across all locations. This included a message from the directors, a welcome to new starters, details about vacancies, human resource and operational updates.

**Learning, continuous improvement and innovation**

- During our inspection, we spoke with SpaMedica's speciality doctor. We found they were passionate about research and learned of SpaMedica's involvement with the global vision database and the work being undertaken with the UK national eye health survey. They also provided medical advice and support to patients across all sites, including YAG laser and complex pre and post-operative patients.
- SpaMedica was working with clinical commissioning groups and local charities to support a project within schools promoting eye health.
- SpaMedica were also developing patient group directives to enable staff to administer pre and post-operative medicines to patients within set criteria.
- SpaMedica was in the process of rolling out an electronic stock and medicine ordering system which would improve the way consumables were ordered and minimise over stocking and waste.
- The company had strengthened its governance processes during 2018, this included the introduction of various forums to ensure robust governance and oversight at a local and corporate level, electronic incident reporting, complaints management and risk registers.
- The company had established a MAC during 2018 to provide medical oversight and input for clinical procedures and to address any concerns relating to clinical practice issues.
- The service had recently introduced an evening de brief. This was used to reflect on the day and included how many patients were seen, any cancellations or did not attend patients (DNA's), any complaints and what these were relating to, any issues with facilities/equipment, any agency or bank usage and any staff movement to or from other sites.

# Outstanding practice and areas for improvement

## Outstanding practice

The service provided a 24-hour, seven day on call service and managed any post-operative complication in house, whenever possible, rather than sending patients to an NHS provider.

Post-operative complication rates were consistently better than the national average.

The company submitted all patient outcome data to the national ophthalmology database audit (NODA).

Patient outcomes were better than the Royal College of Ophthalmology targets.

Referral to treatment times were much better than the England average.

The service had maintained positive patient outcomes and referral to treatment times despite service growth from 8402 cases in 2015 to 25000 cases in 2018.

SpaMedica's speciality doctor was passionate about research and we learned of SpaMedica's involvement with the global vision database and the work being undertaken with the UK national eye health survey.

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should ensure that all sterile equipment is stored in an appropriate designated area.
- The provider should ensure they always use a registered interpreter for people who require one.