Spamedica Limited

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spamedica Limited is operated by Spamedica Ltd. The service is located in Liverpool and facilities include one operating theatre, four consulting rooms and a waiting room.

The service provides cataract surgery and yttrium-aluminium-garnet laser (YAG) capsulotomy services for NHS patients over the age of 18 years.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 19 September 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.

Services we rate

We rated it as **Good** overall.

We found good practice in relation to surgery:

- The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved outcomes for patients that were consistently better than the national average.
- Key services were available seven days a week along with a 24 hour advice line to support timely patient care. Additional appointments were scheduled at weekends to meet patient demand.
- The service planned care to meet the needs of local people, took account of patients' individual needs and worked with others in the wider system and local organisations to plan and delivery care. People could access the service when they needed it and waiting times were in line with the national standard.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers made sure staff were competent. Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

We found areas of outstanding practice in surgery:

Summary of findings

- Staff worked especially hard to make the patient experience as pleasant as possible.
- The service achieved good outcomes that were continually monitored with patients reporting a positive experience.
- The service had an endophthalmitis box on site in case of an emergency.

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

Name of signatory

Ann Ford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Good** 	We rated this service good in safe, caring, responsive and well-led and outstanding in effective.

Summary of findings

Contents

Good

Spamedica Limited

Services we looked at;
Surgery.

Summary of this inspection

Background to Spamedica Limited

Spamedica Limited is operated by Spamedica Ltd. The service opened in 2014. It is a private clinic in Liverpool. The clinic primarily serves the communities of the Merseyside and the surrounding areas 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). The registered manager had been in post for nine weeks. However, the service has had a registered manager in post since it opened.

Our inspection team

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

Information about Spamedica Limited

The service was located on the ground floor of a shared building. It has one operating theatre and four consulting rooms and is registered to provide the following regulated activities:

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

During the inspection, we visited all areas. However, the service did not have any operations booked on the day we visited therefore we observed pre-operative care. We spoke with seven staff including registered nurses, health care technicians, optometrist and senior managers. We spoke with six patients. During our inspection, we reviewed four sets of patient records and four staff files.

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 service has not previously been rated.

In the reporting period March 2018 to February 2019 there were:

- 1941 cataract surgery procedures
- 599 YAG laser procedures
- 2314 Outpatient first attendance
- 1947 Outpatient follow up attendance

Ten surgeons worked regularly at the hospital under practising privileges. There were three registered nurses employed, one optometrist, six healthcare technicians and one patient co-ordinator.

Track record on safety

- No Never events
- There were no serious incidents, no deaths and no incidents classified as severe harm.
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Meticillin-sensitive Staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-coli

The service had not received any complaints between March 2018 and February 2019.

Services provided at the clinic under service level agreement:

- Clinical and or non-clinical waste removal
- Out of hours call handlers
- Sterilisation / Decontamination
- Pathology
- Interpreter services
- Cleaning

Summary of this inspection

- Confidential waste.

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 it as **Good** because:

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

Summary of this inspection

Are services effective?

Outstanding 

We rated it as **Outstanding** because:

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved outcomes for patients that were consistently better than the national average.
- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff offered patients enough food and drink to meet their needs and maintain their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. The service engaged with external stakeholders to enhance the patient experience.
- Key services were available seven days a week including a 24 hour advice line to support timely patient care. Additional appointments were scheduled at weekends to meet patient demand.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Are services caring?

Good 

We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Summary of this inspection

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

Are services responsive?

Good

We rated it as **Good** because:

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

Are services well-led?

Good

We rated it as **Good** because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Summary of this inspection

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

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

We rated it as **good.**

Mandatory training

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

Annual mandatory training for all staff included topics such as health, safety and welfare, conflict resolution, moving and handling (level two), information governance, infection control, and fire safety.

Training was accessed either via e-learning or within a classroom setting.

Compliance with mandatory training was monitored by a designated lead in training who was based at another location.

Data provided showed overall compliance for staff ranged from 75% (basic life support) to 100%. We were informed staff were due to complete basic life support training in October 2019.

Core of knowledge laser safety training was mandatory. Data provided showed that 13 of the expected 15 staff had completed the training within the past three years.

Safeguarding

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

The hospital manager was the safeguarding lead and had recently completed level three in safeguarding of vulnerable adults. The director of clinical services was a registered nurse and has been booked to attend level four safeguarding training later this year.

All staff were aware who this was and how to contact them if required. Staff we spoke with were aware of their role and responsibilities in safeguarding and knew how to raise matters of concern appropriately.

Data confirmed 80% of non-clinical staff and 89% of clinical staff had completed safeguarding of vulnerable adults level two and all managers had completed level three.

All staff had completed safeguarding children (level 2).

Training in safeguarding was provided via e-learning, however, following our inspection we were informed the director of clinical services was looking into face to face training for staff.

Staff had access to a safeguarding policy for adults and a separate policy for children that had recently been updated. The policies included guidance for staff in relation to types of abuse, individual's roles or responsibilities, what staff should do if a person discloses they are being abused or they suspect abuse; also, there was reference to an app held on computers across the organisation with contact details of local authority safeguarding teams. However, the safeguarding policy for children, we reviewed, referenced the intercollegiate guidance 2014 rather than the updated 2019 and did not include reference to working together to safeguard children (2018).

Good

Surgery

During our inspection, staff we spoke to understood their responsibilities around keeping patients safe and told us they would escalate any concerns they had to their manager.

We observed advice regarding escalating safeguarding concerns displayed in the waiting area and consulting rooms and staff told us they could access contact details of local authority safeguarding services on the computer.

The service confirmed there had been no safeguarding referrals in the last 12 months.

Cleanliness, infection control and hygiene

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

The provider had a designated lead (chief operating officer) along with a nurse lead in infection control.

Staff had access to an infection control policy that provided guidance for staff follow for example hand washing and waste disposal along with management of incidents such as sharps injuries.

All areas we visited along with equipment were visibly clean.

Patients had access to personal protective equipment such as gloves and surgical attire. Staff were observed to adhere to the arms below elbow policy in clinical areas.

Staff and patients had access to hand gel and during our inspection we observed staff washing their hands and cleaning equipment before and after patient care. Hand hygiene reminder posters were displayed above hand washing sinks.

Data provided showed there had been no incidences of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C.diff) or E-coli reported from April 2018 to March 2019.

The organisation completed water testing monthly to check for any legionella contamination; with the results of a test in September 2019 showed all eight areas RAG rated as green.

The service had service level agreements in place with external companies for cleaning and laundry services. Manager told us they had no concerns with these services.

Environment and equipment

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

Staff had access to laser safety local rules specific to the service to support staff and to ensure the safety of staff and patients using the YAG laser were stored within the room that laser procedures were performed.

This included the use of goggles and signage about laser safety and we observed these were available during our inspection.

Access to the laser room was not controlled as the pass access on the door had broken, this meant that anyone could enter the room during laser procedures, putting the patient and others at risk. We observed the requirement for a locked door was included on LPA risk assessment conducted in May 2019.

We raised this at inspection and were informed the broken lock had been reported to the company managing the building on the 28 August 2019. Following our inspection, we received confirmation from the provider that a new lock had been fitted.

Electrical safety testing was completed by an external provider.

There were processes in place to ensure the traceability of lens implants. Each lens had three identity stickers. Following surgery, one was placed in the patient's records, one in the operations register stored in the theatre and the third was placed in a lens replenishment folder to aid stock control.

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

Resuscitation equipment, including a defibrillator was located within easy reach of all rooms at the location.

Guidance for staff including basic life support and anaphylaxis were also available on the resuscitation trolley. However, the algorithm for hypoglycaemia appeared to be more relevant for staff in a hospital setting to follow.

We reviewed daily and weekly checklists for the previous three months and observed these had been completed on days the service was open apart from on one occasion.

We were provided with a copy of the emergency equipment audit from April 2019 and noted overall compliance was recorded as 94%.

The service had arrangements in place with an external company for clinical and domestic waste management. We observed that the disposal of sharps, such as needle sticks followed good practice guidance. All sharps containers we observed were dated and signed upon assembling them with the temporary closure in place.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

There was an optometrist who was the designated laser protection supervisor (LPS) at this location and the service had access to an external laser protection advisor (LPA) who had provided a risk assessment and inspection report. Following our inspection, we were provided with an updated risk assessment and recent action plan with specific actions to take along with expected timelines.

Information relating to the procedure and process was sent out to the patient and discussed with the registered nurse at the pre-assessment appointment. We were told if any additional information was required relating to the patient, the referring clinician were contacted.

Staff had access to guidance in relation to patients with specific conditions such as diabetes and advice on the process for patients with latex allergies.

All patients were required to have a pre-assessment performed to provide information to the surgeon and ensure they were suitable for surgery, the process included:

- Ocular coherent topography (OCT) scans on patients who had presented with or had any previous retinal pathology.
- A detailed eye examination pre-operatively. The images produced could identify other eye related disease for diagnosis.
- A biometry test to calculate the power of the lens that will be implanted during the cataract operation.
- An A-scan test that measured the length of the patients eye to determine the lens selection for patients with dense cataracts.
- An epithelial cell count (ECC) was performed before surgery for patients who were at higher risk of developing corneal issues post operatively.
- Corneal topography map on those patients who had presented with corneal problems pre-operatively to assist with prognosis.
- A couch test to ensure they could lie flat for a period of time during their procedure.

Patients who were at a higher risk of complications were identified during their pre-assessment. We were told patients with a risk score of 8% and above of posterior capsule rupture were added to the complex case list with a specialist vitreoretinal surgeon performing the procedure at another location in the north west.

Data provided showed 13 complex patients had been redirected to the other location for their treatment from October 2018 to September 2019.

On the day of surgery staff undertook basic observations temperature, blood pressure, heart rate and blood glucose for those patients with diabetes. Any patients who observations exceeded the expected limits would have them repeated up to three times and any concerns were escalated to the surgeon whose decision it would be as to whether to operate.

The service had recently introduced daily safety huddles to discuss staff responsibilities, theatre lists and any concerns, operation sites were clearly marked and a revised version of the World Health Organisation (WHO) Surgical Safety Checklist for cataract surgery was used to keep patients safe.

We were told quarterly audits of the WHO checklist were performed. We observed a copy of a recent audit performed in September of ten records and showed 100% compliance.

Data showed that all qualified nursing staff had completed training in advanced life support in 2018. However, managers told us training requirement for life support had

changed and a recent decision had been made that it was more relevant for staff to attend immediate life support training. Data provided showed one qualified nurse had attended this training so far.

In the event of an emergency, staff told us they would dial 999 and the patient would be transferred to a local NHS hospital.

The service offered a 24 hour clinical emergency support service for patients. Calls were triaged by an optometrist and advice given and any concerns were escalated to a specialist doctor on call.

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

Nursing and support staffing

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

The service had three registered nurses, six health care technicians, two operating department practioners and one optometrist who worked across two locations in the Merseyside area.

We were told at the time of inspection there were two whole time equivalent vacancies for registered nurses and one nurse was due to commence employment the following week.

We reviewed examples of rotas and saw that it was clearly identified what activities were planned including any new starters or training as well as clinics and surgery. Staff were allocated to the planned activities.

Staff sickness for registered nurses during May 2018 to April 2019 was 0% apart from October 2018 that reported 7.5%. For the same time period staff sickness for healthcare technician was on average 1.25%.

Data provided showed from May 2019 to April 2019 there had been a reduction in the use of agency trained nurses from an average of 36% (May 2018 to December) to 3.7% average (January to April 2019). Staff confirmed agency staff were now rarely used and data showed there were no unfilled shifts. No other staff groups reported any agency use.

From May 2018 to April 2019 turnover for was 50% for operating department practioners, 50% for other staff, 40% for registered nurses and 20% for health care technicians. The service did not have a target for turnover. However, the number of people in the data was low and therefore reported as a high percentage.

During our inspection, managers told us there had been a lot of staff movement due to promotion and transfer to other locations within the company.

Medical staffing

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

The service employed ten consultant ophthalmologists under practising privileges, of those six had performed between 10 and 99 episodes of care and four had performed over 100. 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.

Managers told us theatre lists varied from one to two days a week dependent upon need and the medical director who was a qualified ophthalmologist, told us they would provide cover for clinics or theatre, if required.

Records

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

Patient details were collected and stored on the organisations electronic records system. This included information following pre-assessment, theatre, discharge and post-operative care.Paper records were maintained for

consent, demographics, copy of biometry, outcome forms and referrals. All scans could be viewed electronically. Biometry scans could be viewed electronically as well as printing of hard copies if required at the hospital.

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

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

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

Records were stored securely in the reception area.

Monitors could only be viewed by reception staff.

Records followed patients and stayed in rooms with staff.

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

A records audit, in July 2019 was carried out where eight patient records were reviewed. There was 90% compliance. Areas of non-compliance included printing of name on prescription chart, consent and WHO checklist along with time not documented. The plan was to re-audit in September.

Data provided stated designated staff with authority arranged for patients medical records to be removed from site in secure locked transport carriage boxes by the organisations internal transport service.

Each transferred patient record was recorded by completing a file transfer form along with entering the details on the organisations patient administration system (PAS) system with the date the request of transfer and the date received at specified location. The recipient confirmed receipt of the patient record as soon as it arrived by signing the file transfer form.

Confirmation the patient record had been stored in the patient records area of the required location was also recorded.

All paper records of discharged patients were scanned and indexed to be retrieved on request for planned follow up appointments. All clinical diagnoses and episodes of treatment records were stored electronically and were available at all sites in the case of an unplanned follow up.

Patient records sent externally were by courier via recorded delivery. A log of all records dispatched from our patient records department included the date sent, name, designation and location of person to whom the records were sent, service username and volume of records sent.

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

Medicines

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

The service used topical and local anaesthesia to the eye only. Drops were prescribed using patient specific directions (PSD). These were administered by health care technicians who recorded on the paper PSD and also in the patients electronic record.

We reviewed three prescriptions and noted that staff had signed to confirm they had administered the eye drop but had not printed their name.

The medicines management policy was reviewed and referred to patient group directions as well as PSD's. The company were planning to implement PGD's following agreement from local commissioning authorities. A patient group direction (PGD) is a written instruction that includes the administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The service had plans to introduce PGD's following consultations with commissioners.

The service stored diazepam to be available for patients who were identified as anxious prior to surgery. It was stored appropriately, and records completed for checking and administration. The prescribing of diazepam was included on the prescription chart with other medicines given following PSD's. We reviewed three patient records completed prior to our inspection and noted it was not clear when it was administered. We were told this had recently been addressed and we were shown an updated version that was now in use and included the time of administration.

There was a service level agreement in place with an external pharmacy provider.

There was no controlled drug accountable officer (CDAO) at time of inspection although training has been planned for November 2019 for hospital and area managers within the organisation.

The medicines we sampled, in cupboards and fridges, were all within their expiry dates.

The temperature of the clinical fridge was monitored and recorded appropriately, including the maximum and minimum ranges.

A medicines audit was carried out in August 2019, by the external pharmacy company where a number of recommendations were made. The action plan showed that all actions had been completed. There were plans to increase internal pharmacy audits later in the year.

During our inspection, staff told us of the actions taken following the audit.

Patients were provided with discharge medicines of drops. These were labelled for dispensing and included manufacturer's instructions. Staff checked that patients were confident with administering the drops.

Trained nurses received training in dispensing medicines and data provided showed three out of the four had completed the training. An additional two recently recruited nurses were planned to attend the training as part of their competencies.

Data received showed between March 2018 and February 2019 there was one medicine incident relating to eye drops instilled into the wrong eye that resulted in no harm. We observed this has been reported as an incident and action taken to prevent it from occurring again.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback.

Guidance for staff to follow in relation to reporting and managing incidents was documented within the serious untoward incident policy and the critical incident policy. The serious untoward incident policy included responsibilities around duty of candour and we observed this was due to be reviewed April 2019.

Incidents and near misses were reported on the electronic reporting system and the hospital manager was responsible for review and if required, investigating.

The service had reported no serious incidents or never events reported from May 2018 to April 2019.

Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic barriers are available as at a national level and should have been implemented by all healthcare providers.

Data provided prior to our inspection showed from March 2018 and February 2019 the service reported 15 clinical incidents, of those

- 11 resulted in no harm
- 3 low harm
- 1 moderate harm.

During the inspection, the manager confirmed that the incident reported as moderate harm was because there was initially concern from an external optician that the lens had cracked. However, following a review of the patient, it was identified this was not the case and was therefore no harm. The area manager told us they had opened duty of candour with the patient and were continuing to offer support the patient.

Staff we spoke to were aware of the principles of duty of candour and had access to a recently revised policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents 'and provide reasonable support to that person.

Good

Surgery

Are surgery services effective?

Outstanding ☆

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

The service followed the Royal College of Ophthalmologists (RCOphth) standards.

There were policies and standard operating procedures in place to support practice on the organisations intranet that was accessible to all staff.

The service carried out quarterly clinical audits that covered key topics. We were told any audits that were less than 85% compliant, had actions identified, and the audit was repeated one month later.

The clinical audit process was undergoing a national review as part of a recently drafted clinical governance strategy.

The service provided an audit matrix that included hand hygiene, clinical room audit, infection control, fridge temperatures and emergency equipment in theatre. Audits were carried out with a compliance standard of 85%. If compliance was below, we were told a re-audit was carried out the following month. Data showed compliance above 94.8% on audits performed in January, February and March 2019. We observed actions had been taken to address requiring action. The audit matrix also stated in April 2019, hand hygiene audits were 80% and 96% in June 2019. We requested a copy of the hand hygiene audits for April and June, however at the time of reporting we had not received this.

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

Nutrition and hydration

Staff offered patients enough food and drink to meet their needs and maintain their health.

Hot and cold drinks and biscuits were available in waiting areas free of charge for patients and those accompanying them.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Patients were administered local anaesthetic and pain relief during their procedure.

Following surgery, patients were asked about their experience including pain and comfort and this was fed into the patient reported outcome measures (PROMS).

During the month of August in 2019, 97% of patients reported no pain, 6 % reported mild pain and no patients reported severe pain.

Patients were provided with a leaflet which gave advice on expected post-surgery symptoms and guidance if excessive or increased pain is experienced.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved outcomes for patients that were consistently better than the national average.

The service submitted data for inclusion in the National Ophthalmic Database Audit (NODA).

The data submitted by the provider to the audit, of 1,396 operations, showed that both the adjusted posterior capsular rupture rate (0.4%) and visual acuity loss rate (0.1%) were significantly better than the NODA benchmark of less than 1.1% and 0.9%.

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

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

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Good

Surgery

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

New starters attended a corporate two day induction that was delivered at the providers headquarters. The induction included shadowing a patient through their journey.

Managers made sure staff received any specialist training and induction for their role.

The service had a skills matrix with role allocated competencies for staff to complete for example training in specific equipment and administering eye drops. We were provided with data that showed that between 72% (nine out of 11) and 100% of staff had completed training relevant to their role. Two recently recruited trained nurses were not included in the data.

The training was facilitated by a designated training team at the providers headquarters.

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

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

Staff told us they felt supported to develop their roles and skills.

Data provided showed all staff had received their annual appraisal.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. The service engaged with external stakeholders to enhance the patient experience.

During our inspection we observed good interaction and a positive working environment with all staff and patients.

Effective working with external stakeholders, commissions, opticians and GP's.

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

Seven-day services

Key services were available seven days a week including a 24 hour advice line to support timely patient care. Additional appointments were scheduled at weekends to meet patient demand.

The service was opened six days a week and staff told us this could be extended to seven days dependent upon need.

Post operative patients had access to a 24-hour, seven day on-call service for advice and assistance. The phone calls were triaged by nurses and optometrists.

There was an on-call team consisting of a consultant and registered nurse who could see the patient at a hospital for review or treatment.

Health promotion

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

Patients were given discharge advice both verbally and written leaflets that included advice about keeping the eye clean as well as driving or operating machinery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The provider had a Mental Capacity Act policy and a consent policy that provided guidance for staff to follow. Both were found to be in date.

Data provided showed 89% of clinical staff and 80% of non clinical staff had attended training in the mental capacity act.

If patients lacked capacity to make their own decisions staff assessed care in the best interests of patients and involved their representatives and other healthcare professionals

appropriately. This included referring back to the NHS for care and treatment. This included referring back to the NHS for care and treatment, including an independent mental capacity advisor (IMCA) where appropriate.

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.

Staff made sure patients consented to treatment based on all the information available.

Written consent was obtained prior to surgery and we observed consent clearly documented in the three records we reviewed.

During our inspection, we observed practice of obtaining verbal consent and noted staff checked patients understanding of their reason for attendance at the pre-assessment clinic.

There was an interpreter service available to help with consent for patients whose first language was not English, these were pre-booked to provide either face to face or telephone support. Staff told us, they would not use family members for interpretation.

Are surgery services caring?

Good

We rated it as **good.**

Compassionate care

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

Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Compliments were recorded on the organisations electronic reporting system shared at clinical governance meetings. Examples we were provided with included 'I will miss coming to Spamedica for my appointments as I always felt valued as a person and not just another patient and 'a very nice bunch of people couldn't fault the care I have been given thank you'.

We observed two patients, during clinic pre-assessment consultations with different staff members. All introduced themselves to the patient and explained all care and treatment.

The service submitted feedback data to the NHS Friends and Family Test. Between November 2018 and April 2019, 100 % of patients would recommend the service, with a response rate ranging from 94.5% to 98.6%.

During our inspection, staff told us of an occasion where they had rearranged and brought surgery forward so a patient could fly to another country to see their dying loved one.

Patients were respected and their privacy and dignity was maintained. We observed staff communicating with patients and their families in a respectful and considerate manner.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

One person who had returned to the provider for surgery told us staff were 'brilliant' and they wouldn't go anywhere else for treatment.

We were told of examples of patient who staff continued to be available for the patient for any ongoing support.

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

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand.

Good

Surgery

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff told us that no patient would undergo a procedure without being fully informed and supported throughout the process.

During our inspection, we observed staff explain clearly to the patient what to expect at each stage the process and offered reassurance. Staff ensured patients were comfortable and did not feel rushed.

Patients we spoke with felt fully informed about what to expect prior, during and following their procedure.

A chaperone policy had recently been introduced that explained staff roles and responsibilities and arrangements for a chaperone and hand holders were available during their procedure. However, we did not see any signs in any of the areas we visited explaining a chaperone service was available. During our inspection, patients had attended their appointments with their family.

Are surgery services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population.

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

Facilities and premises were appropriate for the services being delivered.

Patients were given a choice of appointment to suit their needs.

During March 2018 to February 2019 there were:

- 599 YAG laser procedures
- 1941 cataract surgery procedures
- 2314 Outpatient first attendances
- 1947 Outpatient follow ups.

Information was available on the organisations website including how to get to the location via public transport or car. Car parking facilities were available at a reduced cost.

The service was routinely open six days per week, although extra lists were added when there was an increased demand.

The provider website included patient stories that could be viewed at home. Alternatively, free DVD's were available for patients to take home and watch prior to their planned surgery.

Meeting people's individual needs

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

Patients with reduced mobility accessed the service through an alternative entrance and was chaperoned by a member of staff to the waiting area and disabled toilets were available.

Free patient and carer transport was offered within a 10 to 30-mile range of the hospital with patients safety to travel risk assessed individually. Drivers collected patients from their home with a reminder the day before of the expected time.

The service could accommodate bariatric patients who were able to transfer independently on the theatre table. The area manager told us they were looking at the possibility of providing additional resources to be able to offer the service out to people who required additional support, such as hoisting onto the theatre table.

There were ten members of staff who worked across this and another location who were dementia champions and had completed dementia training.

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

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

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

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed time frames and targets.

Referrals were received by phone and patients were contacted within 48 hours to book an appointment

Following confirmation of their appointment, patients were sent out written details of their appointment, this was then followed up by a telephone call reminder 48 hours prior to their attendance.

Patients were offered a choice of appointment, including weekends. The services referral to treatment target was six to seven weeks. Between May 2018 and April 2019, the average waiting time from referral to pre-assessment clinic was 24 days. For the same time period, the average waiting time between pre-assessment clinic and surgery was 26 days.

Waiting times from time of arrival to departure through each stage of the patient journey were monitored as part of key performance indicators to monitor and action if there are areas that need addressing. Data provided showed during April and May 2019 patients waited on average between seven and 15 minutes to be seen in the pre-assessment clinic and on average patients waited on average 8 minutes to be treated for YAG and 43 minutes for treatment.

Waiting times were displayed within the waiting area for patients to see.

The service had recently introduced a standard operating policy for the management of patients who did not attend their appointments this included contacting the patient and their next of kin and sending a letter out with a further appointment.

Data provided showed during March 2018 to February 2019, 18 procedures were cancelled due to non clinical reasons, of those 14 were offered another appointment within 28 days. During inspection we were told that the appointments were cancelled due to equipment failure which was resolved later the same day.

For the same reporting period, data provided prior to inspection showed there were two unplanned returns to theatre. However, the service confirmed both patients had planned returns to theatre following the complexities of the first surgical procedure.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service had a complaints policy that provided guidance for staff to follow in receipt of a verbal or written complaint along with individual responsibilities and actions to take within set timelines.

The chief operating officer reviewed any investigation and the hospital manager issued the final response letter to the patient. The organisations electronic system included the investigation, relevant statements, documents and actions or learning. Trends and learning were shared at senior meetings and cascaded to staff at daily huddles, email,newsletters and team meetings.

During our inspection we observed complaints leaflet in the reception area and information on the website as how to complain to the service along with details of the Parliamentary and Health Service Ombudsman (PHSO) if the complainant wasn't satisfied with the response.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers told us they shared feedback from complaints with staff and learning was used to improve the service.

Data provided showed the service received no complaints during March 2018 and February 2019 and managers confirmed none had been received this year.

Good

Surgery

Are surgery services well-led?

Good

We rated it as **good.**

Leadership

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

The organisation had a board that consisted of a chief executive officer, chief operations officer, chief implementation officer, chief finance officer, medical director and director of clinical services.

The service was led by the area manager and the recently appointed hospital manager.

The hospital manager had experience within the ophthalmology private sector. There was a planned period of training, induction and mentorship with an increased presence from the experienced area manager and senior leadership team to support the manager. The hospital manager told us they felt supported within their role by all levels of managers.

All staff we spoke to told us managers were visible and approachable.

Vision and strategy

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

The organisation vision and strategic objectives was every patient, every time. no excuses, no exceptions and their aim was to deliver a world class service by excelling in the care standards to ensure all patients are cared for safely and effectively and to be the patients first choice for cataract assessment and surgery.

The organisation values were included in induction for all staff.

Staff we spoke to were aware of the vision and strategic objectives.

Culture

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

Staff felt fully supported by their immediate manager and senior managers. Although the senior managers were not based at the location, staff told us they were visible as they visited the location on a regular basis.

Staff told us they felt valued and were comfortable in raising concerns directly with their line manager and to the registered manager. Staff were proud of the department they worked in and providing the service to patients. During our inspection we observed positive working relationships and engagement with patients including the medical director sitting and chatting to patients within the waiting area.

Governance

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

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

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

During our inspection we reviewed four staff files and found evidence of a disclosure and barring check, health checks and employment history. However, we did not observe evidence of references received in three of the files and in one surgeons file. We also did not see evidence of initial checks of the persons professional registration although it was documented within a letter from human resources that it had been included.

Following a recent inspection at another location, the provider had recently updated the recruitment policy to reflect changes that included reference and health checks and were conducting risk assessments of medical staff employed under practising privileges.

There was a clear governance structure with clear roles and responsibilities.

A director of clinical services had recently been appointed to focus on clinical leadership, quality and governance supported by the quality assurance and risk manager (QARM). The director of clinical services reported to the chief operating officer.

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

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

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

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

Audit outcomes were discussed at monthly board meetings.

Monthly operations team meetings and clinical governance meetings included representatives from all the organisations locations. Regular agenda items were discussed with actions identified.

Service level agreements between the provider and suppliers were managed by the facilities team. We were told the agreements along with dates for monitoring were available on an internal system that could be accessed by the hospital manager. We reviewed a selection of service level agreements and noted these were not always signed or dated by both parties and it was not always clear if contracts were indefinite.

There was a service level agreement in place with the laser protection advisor (LPA). Local rules were in place that all staff who operated the YAG laser were required to read and sign.

The laser protection adviser (LPA) was available to provide support and guidance regarding the use of the laser. We reviewed a copy of the LPA certificate; this was current, although the name of the LPA was included in the training companies list of radiation protection adviser's (RPA) rather than LPA's.

Managing risks, issues and performance

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

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

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

The service had a business continuity plan that reflected actions to take in response to untoward events effecting service delivery such as IT issues or severe weather.

The service had a risk register. We reviewed the risk register and saw that each risk was accountable to the hospital manager, control measures in place to reduce the risk along with the review date. However, there was no information about when a risk was first identified, when it was added to the register or when it had last been reviewed. The majority of risks documented were potential incidents or issues that may occur rather than a current actual risk. For example, 'sub-optimal treatment of any patient', premises unexpectedly not available and patients becoming unwell within their care.

Following factual accuracy, the provider told us that all risks had a start and review date. However, this information was not included when a report was run and the quality assurance manager was currently looking at another way to display this data when reporting.

During our inspection we observed a senior management rota displayed in staff areas, to identify who staff should contact if there were any issues or concerns.

Prior to inspection we were provided with copies of minutes from three team meetings held earlier in the year. We observed each of the minutes did not have the date or location of the meeting, who attended and chaired the meeting and there was no set agenda. The document consisted of a list of points that were discussed, and these included operational and governance issues, but we did not see evidence of timelines against actions or of actions being completed. However, the minutes of the last two meetings provided following our inspection showed the date of the meeting, attendees, actions required along with a responsible person.

Managing information

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

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

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

Minutes from operational meetings included concerns about data breaches across the organisation, such as letters being sent out with other patient letters and also theatre list in with these letters.

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

During our inspection we observed information relating to General Data Protection Regulation visible within staff areas.

Engagement

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

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

There was a whistleblowing and raising concerns policy, however, this was passed their review date of May 2019.

Education evenings and events for community optometrists were held to improve continued care and cross provider engagement to support ongoing patient care in the community.

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

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

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

Social events were held throughout the year to celebrate any success.

Good

Surgery

Staff told us the company held corporate events where all staff were invited and encouraged to engage with each other and staff from other locations at the annual summer and Christmas social events. Staff told us they enjoyed the events.

Staff told us there was positive engagement with their peers and senior managers and gave us examples of when the senior managers had responded quickly and supported them.

The service encouraged and gave patients the opportunity to feedback about their care and experience.

We saw evidence the service had responded to patient feedback with improvements to signage at the location.

Learning, continuous improvement and innovation

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

During our inspection we observed an 'endophthalmitis box' stored securely within the theatre. This allowed for immediate access to all equipment including antibiotics to treat the serious sight threatening complication. The medical director told us having all the equipment on site ensured patients received timely care. We were told surgeons had received training as this was a rare complication. The service had made a dvd for surgeons to watch to refresh their knowledge. The medical director told us they had received positive feedback from staff.

The medical director was passionate about their work. They had carried out research into social deprivation and the impact it is has on cataracts. This has been presented at ophthalmic conferences and was published in a national journal for the medical profession.

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

The service had shared videos of cataract surgery with colleagues that were accepted in the European Society of cataract and refractive library.

The medical director was planning to introduce some additional simulation training sessions for surgeons to enhance skills.

By monitoring outcomes and patient satisfaction, the service was committed to continuous improvement.

The organisation had introduced an optometry accreditation scheme. This involved inviting local optometrist to the location for a presentation about services provided. Following any surgery, if routine, patients could be followed up by an accredited optometrist rather than needing to visit the location.

Outstanding practice and areas for improvement

Outstanding practice

- The service achieved good outcomes that were continuously monitored with patients reporting a positive experience.
- The service had an endophthalmitis box on site in case of an emergency.
- Patients were provided with the organisations "patient stories" DVD where previous patients described their experience to help relieve anxiety. Videos were included in the organisations website.
- The service provided free transport to patients who lived within a set distance from the location.
- The service offered an accreditation scheme for community optometrist.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that local rules and any recommendations from the authorised laser protection advisor are followed safely.
- The provider should ensure that the safeguarding policy for children references current guidance.
- The provider should consider alternative formats for leaflets and website information.
- The provider should consider how to indicate a room is occupied to help prevent interrupting appointments.
- The provider should consider posters to indicate a chaperone is available.
- The provider should consider reviewing service level agreements in line with best practice.
- The provider should consider revising the risk register to evidence date added and review.