Pall Mall Medical Diagnostic Treatment Centre

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

Overall summary

Pall Mall Medical Diagnostic Treatment Centre is operated by Spamedica Ltd. The service is located in Newton Le Willows, Merseyside in a building owned by another registered provider. The service had access to facilities including consulting rooms, clinical areas and a theatre. These facilities were located on the ground and second floor and could be accessed via a lift. Staff and patients had access to designated parking bays.

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 22 October 2019. However, the service was in the process of de-registering and patient activity had ceased on the 18 October 2019. We therefore could not observe care or speak with patients on the day.

Following our inspection, we contacted five patients to gain feedback of their experience whilst receiving care from the service.

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?

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 inspected but did not rate the service as we could not collect enough information as there was no patient activity on the day of inspection.

However, 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.

Summary of findings

- 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.
- 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.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. They were focused on the needs of patients receiving care. Managers were clear about their roles and accountabilities. The service told us they engaged well with patients and the community to plan and manage services and that all staff were committed to improving services continually.

We found areas of outstanding practice in surgery:

- The service achieved good outcomes that were continually monitored with patients reporting a positive experience.
- Staff told us 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 offered an accreditation scheme for community optometrist.

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.

Ann Ford

Deputy Chief Inspector of Hospitals

Summary of findings

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Background to Pall Mall Medical Diagnostic Treatment Centre

Pall Mall Medical Diagnostic Treatment Centre is operated by Spamedica Ltd. The service opened in 2014 and 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 vision after cataract surgery).

The hospital has had a registered manager in post since it opened. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC on 11 October 2019.

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 Pall Mall Medical Diagnostic Treatment Centre

The service accessed consulting rooms, clinical areas and a theatre that is owned by another registered provider. The consulting rooms and clinical areas were located on the ground and theatre was located on the second floor of the shared building. Staff and patients had access to designated parking bays.

The service is registered to provide the following regulated activities:

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

At the time of inspection, the service was in the process of de-registering the location and equipment belonging to the provider was being moved to alternative locations. Senior managers, managers and staff removing equipment and consumable were on site but all other staff including trained staff and Optometrist had been relocated to another nearby site.

During the inspection, we visited the consulting room where YAG was performed and the patient waiting areas. However, we did not visit all areas including theatre as this was being utilised by another provider at the time of inspection.

We spoke with five staff consisting of senior managers and managers. All other staff had been transferred to an alternative location where care and treatment was being provided. We reviewed four sets of patient records and three staff files.

We could not observe care or speak with patients on the day as patient activity had ceased on the 18 October 2019. Following our inspection, we contacted five patients to gain feedback of their experience whilst receiving care from the service.

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 July 2018 to June 2019 there were:

- 2,829 visits to the operating theatre
- 4,002 day case attendances
- 2,669 outpatient attendances.

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

Summary of this inspection

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:

- Out of hours call handlers
- Sterilisation / Decontamination
- Pathology
- Interpreter services
- Access to rooms and services at the location
- Pharmacy

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We inspected but did not rate safe

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff had training on how to recognise and report abuse, and there were processes in place to escalate concerns.
- 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 completed and updated risk assessments for each patient and removed or minimised risks.
- 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 told us that they regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.
- We saw evidence that 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 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.

Are services effective?

We inspected but did not rate effective

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

Summary of this inspection

- 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.
- 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.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. The service engaged with external stakeholders to enhance the patient experience.
- Staff supported patients to make informed decisions about their care and treatment. We observed in patient records we reviewed that national guidance was followed to gain patients' consent.
- Staff assessed and monitored patients regularly to see if they were in pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance.
- Patients told us staff provided practical support and advice to lead healthier lives.

Are services caring?

We inspected but did not rate caring

- Patients told us that staff treated them with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Patients told us that staff provided emotional support to minimise their distress.
- Patients told us staff involved them to understand and make decisions about their care and treatment.

Are services responsive?

We inspected but did rate responsive

- 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.
- The service was inclusive and took account of patients' individual needs and preferences. Staff told us that they made reasonable adjustments to help patients access services.
- 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.

Summary of this inspection

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

Are services well-led?

We inspected but did not rate well-led

- Leaders had the skills to run the service. They understood and managed the priorities and issues the service faced.
- 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 understood and knew how to apply them and monitor progress.
- The service promoted equality and diversity in daily work and provided opportunities for career development. Leaders told us there was an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Records showed staff had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. Records showed staff identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Leaders told us that 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 told us they 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.
- Leaders were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

We inspected but did not rate safe

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 100% compliance for all staff apart moving and handling for clinical staff that showed 66% compliance. Data provided stated that the training was booked for staff to attend in October 2019.

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

Safeguarding

Staff had training on how to recognise and report abuse, and there were processes in place to escalate concerns.

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

Data confirmed all clinical staff and two (66%) of the three non-clinical staff of had completed safeguarding of vulnerable adults level two and all clinical staff had completed level three.

All staff had completed safeguarding children (level 2).

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

Managers told us they would discuss scenarios and go through the safeguarding flow chart with 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).

We observed advice regarding escalating safeguarding concerns displayed in the waiting area and consulting rooms.

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.

Surgery

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 reported all areas were clean and tidy during their visit.

Staff had access to hand gel and personal protective equipment such as gloves. 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.difficile) or E-coli reported from July 2018 to June 2019.

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 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 and the use of goggles and signage about laser safety. However, we observed the local rules on site were written in 2017 with a review date of 2018. We raised this at the time of inspection and staff provided local rules from 2018 and 2019.

The laser safety local rules were stored in a sealed plastic box along with equipment such as goggles, and we were told these were taken to the room the room when the YAG laser was being used.

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.

Resuscitation equipment, including a defibrillator was located on the first floor at the location. We reviewed daily and weekly checklists 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 for 2019 and observed overall compliance was above the target of 90%; March (90%) ,June (99%) and September (100%).

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

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 an inspection report. During 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 retinol 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 ten complex patients had been redirected to the other location for their treatment from October 2018 to September 2019.

We observed in the records we reviewed staff undertook basic observations temperature, blood pressure and heart rate on the day of surgery.

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 the audit matrix for 2019 that showed 100% compliance.

Data showed that in September 2019 all non-clinical staff had completed training in basic life support and all clinical staff had completed training in both basic and immediate life support.

In the event of an emergency, staff were expected to 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 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.

Each treatment room had a phone that had a tannoy facility. In the event of an emergency, a call could bemade 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.

Managers told us the service had five registered nurses, five health care technicians, one operating department practioner, one optometrist and three patient coordinators who worked across two locations in the Merseyside area.

We were told at the time of inspection there were no vacancies at the location.

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 August 2018 to July 2019 was 0% apart from May 2019 that reported 4.9 %. For the same time period staff sickness for healthcare technicians and operating department practioner was also 0% apart from July 2019 that reported a sickness rate of 1.6%.

Data provided from August 2018 to July 2019 showed the majority of agency usage was for registered nurses in theatre with an average of 17.5% and 4.6% was reported for other registered nurses. Staff confirmed the same agency staff would be used and data showed there were no unfilled shifts. No other staff groups reported any agency use.

From August 2018 to July 2019 turnover was 33 % for healthcare technicians in outpatients and 33% for other staff. All other healthcare technicians, operating department practioner and trained staff were reported as 0%. 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.

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.

Data provided for July 2019 showed the service employed 15 consultant ophthalmologists under practising privileges,

of those one had performed between one and nine episodes of care, 11 had performed between 10 and 99 episodes of care and one 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 were arranged 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 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.

Monitors could only be viewed by reception staff.

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

A quarterly records audit was performed, and data provide showed compliance for March 2019 was 90% and June was 89%.

In July 2019, an audit was carried out where eight patient records was reviewed. There was 90% compliance. Areas of non-compliance included printing of name on the 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 available on site.

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 prescription and also in the patients electronic record.

We reviewed four PSD and found these to be completed.

We reviewed two written prescriptions and noted that staff had signed to confirm they had administered the eye drop but on one a qualified nurse had not printed their name, which meant it wasn't clear who had administered the eye drop.

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.

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

During our inspection we were unable to inspect the storage, the reconciliation or expiry dates of medicines as these were stored within the theatre area that was in use by another provider. The service had arranged for a pharmacist from an external company to log and transfer all medicines later that day to another nearby location. We were told a trained nurse was at the location to receive, log and store the medicines as required.

Following our inspection, we were provided with an inventory of all medicines removed and saw these had been listed in chronological order with batch number, quantity and expiry date of each medicine. We noted these were in date.

We were told the service stored diazepam in a locked cupboard and was available for patients who were identified as anxious prior to surgery. The prescribing of diazepam and time administered was included on the prescription chart with other medicines given following PSD's. None of the patients had received diazepam in the records we reviewed.

The monitoring of fridge temperatures was included in quarterly audits and we observed compliance for 2019 was above 90%.

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.

We were told a pharmacy audit had been carried out in October by an external provider and the service was awaiting the report.

Patients were provided with discharge medicines of drops. Take home medicines were audited quarterly and we observed compliance was 100% on all three occasions for 2019.

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 May 2019 and August 2019 there were five medicine incidents reported. We observed appropriate action had been taken to prevent the incidents happening again including retraining a member of staff.

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.

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 were reported on an incident form and the hospital manager was responsible for review and if required, investigating.

The service had reported no serious incidents or never events reported from July 2018 to June 2019.

Surgery

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 July 2018 and June 2019 the service reported 41 clinical incidents, of those

- 34 were categorised as no harm
- 6 low harm
- 1 moderate harm.

We reviewed the investigation following the incident resulting in moderate harm and observed duty of candour had been applied. The manager could verbally demonstrate actions taken. However, we did not see an action plan in place. Since this incident, the service had introduced a root cause analysis template that included an action plan.

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.

Are surgery services effective?

We inspected but did not rate effective

Evidence-based care and treatment

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 90 % 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 90 %. If compliance was below, we were told a re-audit was carried out the following month. Data showed compliance above 90% on all but two audits performed in March, June and September 2019. We observed actions had been taken to address requiring action.

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.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

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).

We were provided with data from two days in October 2019 and observed all 37 patients asked reported no 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).

Data submitted by the provider showed the service had achieved significantly better outcomes compared to national standards for the 1.125 patients who had cataract surgery performed from 1 January to 4 September 2019:

- the adjusted posterior capsular rupture rate was 0.27% (National 1.1)
- the visual acuity loss rate was 0.27% (National < 0.9%)

- 6/12 or better 96.34% (national target >95%)
- refractive outcome within 1D 92.13% (RCOphth >85%)

Outcomes benchmarked across the organisation that identified good practice 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.

Staff were experienced and had the right skills 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 the staff had completed the majority of competencies relevant to their role.

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 were monitored and reviewed at governance and medical advisory committee meetings that focussed on outcomes as well as patient experiences.

Managers confirmed all eligible staff had received their annual appraisal.

Multidisciplinary working

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

Managers told us there was effective working with external stakeholders, commissions, community opticians and GP's.

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

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 demands.

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

Patients told us that staff gave patients practical support and advice to lead healthier lives.

Patients told us they were given discharge advice both verbally and written leaflets that included advice about keeping the eye clean as well as driving.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment.

We observed in patient records we reviewed that national guidance was followed to gain patients' consent.

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 all clinical staff and non-clinical staff had attended training in the mental capacity act.

Surgery

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.

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 four we reviewed.

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.

Are surgery services caring?

We inspected but did not rate caring

Compassionate care

Patients told us that staff treated them with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Patients we spoke to told us they were treated with respected and their privacy and dignity was maintained. One patient told us during their visit they staff knew their name, were caring and they felt like they were part of a family ' and another told us staff were 'very kind and caring'.

The service submitted feedback data to the NHS Friends and Family Test. Between February 2019 and July 2019, between 98 % and 100 % of patients would recommend the service, with a response rate ranged from 81 % to 90%.

Emotional support

Patients told us that staff provided emotional support to minimise their distress.

Staff told us 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.

Patients told us staff were attentive and regularly checked to see if they were ok. One patient told us they were looking forward to going back for further surgery.

Understanding and involvement of patients and those close to them

Patients told us staff involved them to understand and make decisions about their care and treatment.

Patients we spoke with felt fully informed as they had been provided with information before and after their procedure and that staff had clearly explained each stage of the process.

Patients and their families could give feedback on the service and their treatment.

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.

Managers told us staff were available to stay with patients and hold the patients hand to reassure whilst in theatre. They told us if a patient was nervous they would show them around the clinical and theatre area to help alleviate anxiety, they shared an example of showing an anxious patient with a chronic breathing condition that oxygen was available should they require it.

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

We reviewed data collated on two days in October 2019 and observed out of the 37 patients asked:

- 37 stated the surgeon had introduced themselves by name
- 35 felt the surgeon had given them an opportunity to ask questions
- 36 felt that the surgeon had reassured them during the procedure
- 36 would be happy to recommend the surgeon to their friends.

Surgery

Are surgery services responsive?

We inspected but did not rate responsive

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, we observed were appropriate for the services being delivered.

During July 2018 to June 2019 there were:

- 2,829 visits to the operating theatre
- 4,002 day case attendances
- 2,669 outpatient attendances.

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

The service was routinely open six days per week.

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 told us that they made reasonable adjustments to help patients access services.

Patients with reduced mobility were able to access the service as there were lifts to all floors and disabled toilets available.

There were five 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 timeframes and targets.

Referrals were received by phone and pts 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 October 2018 and September 2019, the average waiting time from referral to pre-assessment clinic was 29 days. For the same time period, the average waiting time between pre-assessment clinic and surgery was 23 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 two and ten minutes to be seen in the pre-assessment clinic and on average patients waited on average one minute to be treated for YAG and 18 minutes for cataract treatment.

Surgery

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 July 2018 to June 2019, 22 procedures were cancelled due to clinical reasons and there were no unplanned returns to theatre.

During June 2018 and July 2019 there were 14 procedures cancelled due to non-clinical reasons and all, but one patient was offered a further appointment within 28 days and one was patient was discharged as treatment was not required.

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

Data provided showed the service received no complaints during August 2018 and July 2019.

Are surgery services well-led?

We inspected but did not rate well-led

Leadership

Leaders had the skills to run the service. They understood and managed the priorities and issues the service faced.

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

The service was led by a recently appointed hospital manager who was also the chief operating officer. The previous hospital manager had recently been moved to manage a newly opened location nearby. There was also an area manager who worked across locations in the Merseyside area.

During our inspection we spoke with the previous hospital manager and they told us they felt supported within their role by all levels of managers and that all 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 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.

Culture

The service promoted equality and diversity in daily work and provided opportunities for career development. Leaders told us there was an open culture where patients, their families and staff could raise concerns without fear.

Managers felt fully supported and valued by their senior managers and although the senior managers were not based at the location, staff told us they were visible and could be accessed at any time.

Governance

Surgery

Leaders operated effective governance processes, throughout the service and with partner organisations. Records showed staff 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 three staff files and found evidence of a disclosure and barring (DBS) check, health checks and employment history. However, in one staff members file who had been recruited five months ago we did not observe evidence of references received and the disclosure and barring check had been received following the start of employment. We raised this at inspection and senior managers told us anyone who was awaiting their DBS would always work under supervision.

Following the inspection, we were provided with a risk assessment that had been completed on the day of our inspection and observed one reference was obtained after the start of employment and the other reference was being followed up on the 9 October 2019. The risk assessment had a date of review documented.

Following a recent inspection at another location, the provider had recently updated the recruitment policy to reflect changes that included reference 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. However, the documented date of next meeting was recorded as 2018 in the three of four clinical governance meetings held in 2019 we reviewed.

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. Records showed staff identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Managers told us the number of patients seen had been gradually reduced from around 200 to 50 a month and they had recently taken the decision to stop providing services at this location to allow for flexibility and access to clinical areas when required. We were told has made rearranging appointments more manageable. We were told the service was in the process of contacting patients to rearrange planned appointments to other nearby locations including one that had recently opened. The registered manager was aware of their responsibilities and had notified the CQC.

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 cybercrime attacks, power failure 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, 'failure to comply with policies and procedures and patients becoming unwell within their care.

Prior to inspection we were provided with a copy of minutes from two team meetings held at a nearby location. We observed each of the minutes did not have a set agenda and although a responsible person was documented against actions required, timelines were only documented on one set of minutes. It is therefore, not clear if actions had been taken or remained outstanding.

Managing information

The service collected reliable data and analysed it. Leaders told us that 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.

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

Engagement

Leaders told us they 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.

Surgery

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.

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.

Managers 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 the seating in the clinical areas.

Learning, continuous improvement and innovation

Leaders 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.

The medical director 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.
- Staff told us 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 offered an accreditation scheme for community optometrist.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that current 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 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.
- The provider should ensure all policies are reviewed and reflect current guidance within agreed timelines.