NHS North Derbyshire Community Ophthalmology Service

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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

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

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

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

Overall summary

NHS North Derbyshire Community Ophthalmology Service is operated by New Medical Systems Limited. The service at this location provides outpatients and surgery. The service provided the surgeon to conduct ophthalmic related surgical procedures however the theatre environment, additional theatre staff and day case waiting area, were provided by another provider (the 'host' provider). The service runs and delivers the ophthalmology outpatients element within their dedicated outpatient department. The outpatient department consists of three clinical rooms, an administrative area and a toilet.

We inspected both outpatients and surgery. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 11 September 2017, along with an unannounced visit to the hospital on 20 September 2017.

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

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

The main service provided by this hospital was outpatient services. Where our findings on outpatient services – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the outpatient core service.

Services we rate

We rated this service as good overall.

- The service had processes in place which monitored safe care and treatment provided at this location.
- The service reported no never events, serious incidents, surgical site infections (SSIs) or healthcare associated infections (HCAIs) from April 2016 to March 2017.
- All staff had an awareness of the safeguarding policy and reporting procedure and felt confident in identifying a potential safeguarding incident and the steps they would need to take.
- Medicines were administered to patients in a way, which kept them safe from avoidable harm.
- The service had policies, procedures, and guidelines, which were based on current legislation, evidence-based care and treatment and nationally considered best practice. These were regularly reviewed at the medical advisory committee (MAC) meetings.
- The service submitted patient outcomes to the clinical commissioning groups (CCGs) as part of their contract.

Summary of findings

- Local cataract audits demonstrated positive outcomes for 95% of the patients who underwent the procedure.
- The service followed robust processes when it came to seeking out consent from patients. We observed best practice with the quality of information patients received to enable them to make fully informed decisions. We also observed staff adhering to the two week cooling off for patients who underwent oculoplastics procedures.
- Staff had a strong focus on providing a caring, compassionate and professional service. We observed examples of respectful and dignified care during our inspection.
- The service had processes in place to arrange for additional clinical support to meet patient needs if identified during their consultations.
- The service exceeded the 85% target set in their contract for reviewing patients within eight weeks of being referred. The service regularly recorded a monthly compliance of 100% for meeting referral to treatment times.
- There was a vision and strategy for the service, which all staff were aware of. We observed the mission statement for the service displayed in the outpatient department.
- There were effective governance arrangements in place to monitor quality, performance and patient safety. There was clear evidence that information from all meetings was shared so all staff were aware.
- There was a risk register in place, which the service regularly reviewed. All risks had an owner and mitigating actions recorded.

However:

- The room where the class four laser was operated was not compliant with recommendations from the Medicines and Healthcare products Regulatory Advice (MHRA) guidance and did not have signage in place which complied with Health and Safety (Safety Signs and Signals) Regulations 1996 (11) and related standards. This was entered on to the services risk register; however, we were not assured this had been escalated to the provider risk register.
- There was no on site supervisor to ensure safe usage and adherence to local rules when the laser equipment was in use.
- Staff files did not all contain all the essential evidence within them. The human resources department managed this centrally, however the senior management at this location did not regularly review them to provide assurance all staff were fit and safe to work within the service.
- The outpatient department was compact and concerns were raised around the accessibility for disabled patients, and more importantly the ability to evacuate them safely and swiftly in a fire.
- Staff knowledge around clinical incidents was variable. We observed a near miss during a procedure, which staff did not consider, was a reportable clinical incident.
- We observed staff members not adhering to the surgical policies and procedures of the host provider whilst in the operating theatre.
- The service did not participate in national audits at the time of inspection; it was therefore not possible to benchmark its performance against other providers.
- The service used the World Health Organisations (WHO) surgical safety checklists for all surgical and minor procedures. We observed variable levels of compliance with these checklists and minimal auditing of compliance.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected the outpatient department. Details are at the end of the report.

Heidi Smoult

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 as good because it was safe, effective, caring, responsive to patient needs and well-led. We found: • The service had processes in place to get assurance around environment and equipment used in the theatre setting that belonged to the host provider. • The service had a good track record on safety with no never events, serious incidents, surgical site infections or healthcare associated infections from April 2016 to March 2017. • The service collected outcomes from patients who underwent cataract surgery and used this information to make improvements locally as well as submitting to the clinical commissioning groups (CCGs). • The service observed the two week cooling off period for patients who underwent oculoplastic procedures. • Staff provided emotional support and reassurance to those who were about to undergo their cataract procedure. • The service exceeded the 85% target for patients to be seen within eight weeks of referral. • There were regular meetings between the service and the host provider to discuss governance issues.
Outpatients and diagnostic imaging	Good 	Outpatients was the main activity of the hospital. Where our findings on outpatients also apply to other services, we do not repeat the information but cross-refer to the outpatients section. We rated this service as good overall with requires improvement in safe. We do not rate the effectiveness of an outpatient department. We found: • The service had processes in place, which monitored the safe care and treatment provided. • The service had a good track record on safety with no never events, serious incidents, surgical site infections or healthcare associated infections from April 2016 to March 2017.

Summary of findings

- The service collected patient outcomes on a monthly basis and reported them to the clinical commissioning groups (CCGs) as part of their contract.
- There was a local audit programme in place and feedback was given to staff with actions identified after an audit was completed.
- Patients provided positive feedback about the care and treatment provided by the service and we observed examples of good care and treatment.
- There was a process in place to manage patients who did not attend (DNA) their appointments.
- There was a positive culture within the outpatient department, and staff told us they felt respected and valued.
- There was an effective governance arrangement in place to monitor quality, performance and patient safety.

However:

- We found a breach of Health and Social Care Act (2008) (Regulated Activities) Regulations 2014, specifically regulation 12 safe care and treatment. This was in relation to the use of a class four laser in a room which had no signage which complied with the Health and Safety (Safety Signs and Signals) Regulations 1996 (11) and other relevant standards.
- We also found no on-site laser supervisor to ensure all staff were adhering to the local safety rules and ensuring safe practice.
- The outpatient department was compact and we had concerns around the manoeuvrability and the physical ability to evacuate a patient with mobility difficulties in the event of a fire.

Summary of findings

Contents

Good

NHS North Derbyshire Community Ophthalmology Service.

Services we looked at

Surgery and Outpatients and diagnostic imaging.

Summary of this inspection

Background to NHS North Derbyshire Community Ophthalmology Service

NHS North Derbyshire Community Ophthalmology Service is operated by New Medical Systems Limited. The service is classified as an independent hospital and is located in part of another independent hospital in Barlborough, Derbyshire. The service primarily serves the communities of North Derbyshire.

The service has had a registered manager in post since 25 May 2016. There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has not been inspected since it was registered in May 2016.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two other CQC inspectors. Bridgette Hill, Inspection Manager and Carolyn Jenkinson, Head of Hospital Inspection oversaw the inspection team.

Information about NHS North Derbyshire Community Ophthalmology Service

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the outpatient department during the announced inspection period and the theatre and day case waiting area during the unannounced period. We spoke with six staff including; registered nurses, clinic assistants, reception staff, medical staff and senior managers. We spoke with eight patients and one relative. We also received five 'tell us about your care' comment cards which patients had completed prior to and during our inspection period. During our inspection, we reviewed 11 sets of patient records.

Activity (April 2016 to March 2017)

- In the reporting period April 2016 to March 2017, there were 709 outpatient attendances recorded at the service; of these, all patients were NHS funded. The majority of outpatient attendances were pre and post-operative consultations.
- There were 224 day case episodes in the reporting period; of these, all were NHS funded. The majority of these cases (219) were for cataract surgery. The remaining five cases were for blepharoplasty (four) and excision of a lesion (one).
- The outpatient and day case activity was all provided to patients over the age of 18 years. No children were seen at this service.

Two surgeons worked regularly at the service under practising privileges. The service employed one service manager, one team leader, four clinical assistants and one receptionist. The service relied on registered nurses from a bank to fill positions in the outpatients department.

Track record on safety

- No never events
- One clinical incident was recorded and 15 non-clinical incidents were reported.
- No serious injuries
- No incidences of healthcare associated Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia.

Summary of this inspection

- No incidences of healthcare associated Meticillin sensitive Staphylococcus aureus (MSSA) bacteraemia.
- No incidences of healthcare associated Clostridium difficile (C. difficile).
- No incidences of healthcare associated Escherichia coli (E-Coli) bacteraemia.
- Seven complaints.
- NHS North Derbyshire Community Ophthalmology Service had no accredited services.

Services provided at the hospital under service level agreement:

- Theatre provision, additional staff, equipment and consumables.
- Clinical and non-clinical waste removal.
- Maintenance of medical equipment and environment.
- Pharmacy
- Transportation of a deteriorating patient.

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?

Requires improvement 

We rated safe as requires improvement because:

- The room where the class four laser was operated in the outpatient department was not suitable as there was no signage in place which complied with Health and Safety (Safety Signs and Signals) Regulations 1996 (11) and associated standards.
- There was no onsite supervisor to ensure staff were adhering to safe practice and the local safety rules when the class four laser was in operation.
- The medicines refrigerator did not have an actual reading recorded and staff were unsure of the acceptable maximum temperature.
- We found evidence of in date mandatory training for 50% of the staff working at the service under practicing privileges. There was no record of any training for the remaining 50%.
- The outpatient department for the service was small and the clinical rooms contained multiple items of equipment. The service manager had conducted a fire risk assessment for the outpatient department; however, we were not assured that this covered the manoeuvrability of patients with mobility difficulties, especially those in wheelchairs.
- Staff had completed a hand hygiene practical assessment, however the service did not routinely complete hand hygiene compliance audits within the outpatients department.
- We observed staff not adhering to local infection prevention and control policies in the theatre environment, as they were not bare below the elbow and did not wear a facemask during the surgical procedure.
- The service used the World Health Organisation (WHO) surgical safety checklists for all procedures conducted. However, the service had not audited the compliance with the checklists in the outpatient department, and had only just started receiving audit results of the checklists used in theatre. We were therefore not assured that the use of this tool was embedded in all staff practice.
- We were not assured that all staff who worked for the service were knowledgeable of the incident reporting process and what incidents they should be reporting.

However, we also found evidence of good practice:

Summary of this inspection

- The service had processes in place, which monitored the safe care and treatment provided.
- The service had no never events or serious incidents from April 2016 to March 2017. During inspection, staff told us there had still been no never events or serious incidents reported since the service was registered.
- The service did not report any surgical site infections or healthcare associated infections (HCAIs) from April 2016 to March 2017.
- The service had a strict admission criteria for suitability of surgery at this location. All staff were knowledgeable of this criteria and raised concerns if required.
- Staff who had reported incidents at the service received feedback on the incident and had experienced learning from other incidents when lessons were identified for wider learning.
- Staff had an awareness of the safeguarding policy and felt confident to raise concerns when required. All staff knew who the lead for safeguarding was.
- There were patient group directions (PGDs) for staff who administered eye drops in the outpatient department.

Are services effective?

Good

We rated effective as good because:

- The service had policies, procedures and guidelines, which were based on current legislation, evidence-based care and treatment and nationally considered best practice.
- The service collated patient outcomes on a monthly basis and reported them to their clinical commissioning groups (CCGs) as part of their contract.
- The service had a local audit programme in place, which all staff were involved in.
- All staff had received an appraisal at the time of inspection and told us these were meaningful.
- We observed positive multidisciplinary team working between the staff from the service and the staff from the host provider.
- At the time of inspection, 83% of staff had completed Mental Capacity Act (2005) training and demonstrated a good understanding of capacity.
- The service observed the two week cooling off period for patients who underwent oculoplastic procedures as recommended by professional bodies.

However:

- The service did not participate directly with national audits and therefore could not benchmark their outcomes against other national providers.

Summary of this inspection

- We found gaps in evidence within staff files for some of the staff that worked for the service. Out of the six files we checked, three of these contained all the required documents.

Are services caring?

Good

We rated caring as good because:

- The service reported consistently high friends and family test (FFT) results from April 2016 to March 2017. The results for the service ranged from 91% to 100% during this reporting period.
- All patients spoke positively about the service and used phrases such as 'efficient' 'professional' and 'friendly staff' to describe their care and treatment provided by staff at the service.
- We observed care being provided to patients, which was respectful, compassionate and dignified.
- Patients and their relatives were encouraged to be partners in their care. Staff took their time to provide patients with all the relevant information about their care and answered questions that patients and their relatives had with sensitivity and patience.

However:

- In the area where pre-operative checks were completed, we were not assured that patient confidentiality was maintained at all times, although staff attempted to lower their voices so other patients could not hear.

Are services responsive?

Good

We rated responsive as good because:

- From July 2016 to June 2017, 93% to 100% of patients were seen within eight weeks of referral to the service.
- The service had a process in place for managing 'did not attend' patients.
- The service had access to a translation service for patients whose first language was not English.
- From July 2016 to June 2017 46 operations had been cancelled for non-clinical reasons which were beyond the control of the service. All procedures were rescheduled within 28 days.
- The service had processes in place to arrange for additional clinical help to meet patient needs if identified prior to their procedure.

However:

- Patient information leaflets were only available in English or braille.

Summary of this inspection

- We did not observe any posters or leaflets available in the day case waiting area, which advised patients on the services complaints procedure.

Are services well-led?

Good

We rated well-led as good because:

- There was a vision and strategy for the service which staff were aware of. We saw a mission statement displayed in the outpatient department.
- Staff were positive about the service manager and the influence they had on building a good relationship between the service and the host provider.
- All staff told us they felt supported, respected and valued. Staff told us they enjoyed working for the service.
- There were effective governance arrangements in place to monitor quality, performance and patient safety. There was clear evidence that information from all meetings was shared so all staff were aware.
- The service was aware of their risks and maintained a risk register for this location, which was reviewed regularly at governance meetings. A process was in place to escalate these risks to the provider risk register if the risk was still considered high after mitigation.
- The service provided a comprehensive service pack for the clinical commissioning groups (CCGs) which contained details about the performance of the service and patient outcomes.
- The service engaged with patients and members of the public to seek opinions on how to improve the service they provided.

However:

- As the service did not participate in national audits at the time of inspection, it was not possible to benchmark its performance against other providers.
- The service relied on the human resources team to update and maintain staff records. Staff therefore did not review them regularly to assure themselves all staff had the correct documents and evidence in place.

Good

Surgery

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

Are surgery services safe?

Good

Surgery was a smaller proportion of this services activity. The main service was outpatients and diagnostic imaging. Where arrangements were the same, we have reported findings in the outpatient and diagnostic imaging findings section.

We rated safe as **good.**

Incidents

- There were no never events reported for the service from April 2016 to March 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The service manager told us if an incident occurred in the operating theatre, their staff would complete an incident form and this would be shared with the host provider if there was a requirement to do so. We also saw evidence of incidents, which had occurred in the operating theatre environment, which had been reported by the host provider and discussed at monthly governance meetings. This meant the service was assured that any incident, which occurred in the theatre environment when ophthalmic surgery was being conducted would be reported, investigated and any learning identified from them.
- The service recorded 16 incidents from April 2016 to March 2017. Of these, one was classed as a clinical incident with no harm and the remaining 15 non-clinical incidents. Three of the non-clinical incidents occurred in the surgical services. There was no evidence of any themes or trends in the non-clinical incidents. Any incidents raised by the host provider although discussed, were not recorded on the services log of incidents and therefore no cumulative number available.
- During the unannounced inspection, we observed a near miss incident where the equipment had been set up for a patient including lens selection, however due to dilation problems, a different patient was sent to theatre. The correct procedures were conducted inside the theatre, which identified this before the operation began and the correct lens for that patient selected. Staff from the service being inspected did not feel this was an incident, which required reporting and therefore would not report this; however, the staff from the host provider confirmed this would require an incident report to be completed. The WHO defines a near miss incident as an error that has the potential to cause an adverse event (patient harm) but fails to do so because of chance or because it is intercepted.
- We were therefore not assured that all staff working at the service were knowledgeable about what incidents they should be reporting and that all incidents, which had happened, had been correctly identified and reported.
- See information under this sub-heading in the outpatients section for main findings.

Good

Surgery

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

- The service used their service pack, which they submitted to the clinical commissioning group (CCG) and their balance score card as a way of monitoring safety. Included on this return was surgical site infection data, mandatory reporting of healthcare associated infections and complications from surgery.

Cleanliness, infection control and hygiene

- The host provider maintained cleanliness of the ward environment and theatre environment. The service manager told us they had started to receive copies of cleanliness audits conducted by the host provider, which provided them with assurance for the cleanliness standards.
- If a patient had a known infection, this information would be highlighted by the service on the booking form and the host provider would arrange for additional measures on the day of the operation.
- Information provided before the inspection reported no surgical site infections (SSIs) for the period of April 2016 to March 2017. Further information provided on clinical quality and safety by the service showed no SSIs up until 31 August 2017. Similarly, there were no reported healthcare associated infections (HCAIs) reported by the service for the period of April 2016 to August 2017.
- All surgical equipment used was provided by the host provider and was therefore decontaminated by this provider. Assurance for this process was received during monthly governance meetings with the host provider.
- During our unannounced inspection, we observed the staff member from the service not adhering to the theatre dress standards of the host provider by wearing a facemask during the cataract operation. The staff member told us that this was not mandatory for cataract surgery, and information from the Royal College of Ophthalmologists stated staff should consider wearing facemasks. We raised this with the service manager who stated staff should be adhering to the policies and procedures of the host provider within the theatre department and would therefore address this issue.
- We observed good standards of surgical scrubbing prior to each theatre case; however, we also observed that staff were not compliant with the bare below elbow policy due to additional rings being worn. This was discussed with the service manager who confirmed staff should be compliant with the bare below elbow policy and would therefore address this issue and discuss this with the host provider at their governance meetings.
- See information under this sub-heading in the outpatients section for main findings.

Environment and equipment

- The resuscitation equipment was provided and maintained by the host provider. This was immediately available within the theatre environment for staff from the service to use if there was a requirement.
- All surgical procedures took place in a theatre environment with laminar airflow, which belonged to the host provider. The service received assurance around the suitability of the environment through monthly governance meetings, which took place.
- The staff member from the service had their own settings for the biometric machine, which was used during the procedures. We observed the staff member checking the machine before each procedure, which took place.
- The staff member from the service selected the lenses for each cataract surgery. They checked this with staff members from the host provider prior to conducting the procedure. The staff member from the service was responsible for recording the details of selected lenses.
- Other items of equipment to meet patients' needs, such as a hoist were available in the theatre environment; however, this belonged to the host provider and therefore was serviced and maintained by them.
- The host provider disposed of any clinical, domestic or sharps waste produced during the surgical procedures.

Medicines

- We observed the staff member from the service checking local anaesthetic with staff members from the host provider prior to using this during the surgical procedures.

- The surgeon prescribed medicines for patients to take home following their surgery prior to departing the operating theatre. Staff from the host provider issued the patient with their medication before they discharged them home.
- For our detailed findings on medicines, please see the safe section in the outpatient report.

Records

- The service had integrated care pathways for the surgical procedures they conducted. All staff members, including those from the host provider involved in the patients care documented in these pathways. We reviewed eight sets of notes and found them to be organised and easy to follow, written legibly signed by the consultant and contained clinic letters, communications with patients and referral letters. However, we did find in all eight sets of notes that when staff had signed their entry, they had not printed their name and entered their job description on all occasions.
- The pre-operative assessments were conducted in accordance with guidance from the Royal College of Ophthalmologists. We reviewed eight sets of notes that contained pre-operative assessments and found that all eight sets had evidence of the key areas for assessment being completed; however, the level of details for previous (relevant) medical history and previous (relevant) ocular history was inconsistent. In two sets of notes, the staff member who completed the assessment had ticked a relevant condition, in the other six sets, nothing had been entered. This was highlighted to the service manager.
- In all eight sets of notes we reviewed, we found no evidence of 24-hour post-operative calls being conducted, despite this being part of the pathway documentation. The service manager wanted to complete these, however at the time of inspection, they did not have enough qualified staff to complete these and the clinic assistants had not received appropriate training to enable them to complete these. Evidence from the feedback from patients and calls received on the 24-hour call line did not indicate there was a risk to patients if these calls were not completed.

Safeguarding

- Staff told us if they had concerns about any patients who arrived for their surgical procedure, they had the knowledge to enable them to escalate their concerns and make a safeguarding referral.
- See information under this sub-heading in the outpatients section for main findings.

Mandatory training (if this is the main core service report all information on the ward(s) here.

- The service manager told us the contract between the service and the host provider contained details around the host providers' responsibility to ensure all staff working with the service had up-to-date training. They also told us, if there were any concerns around this, this would be discussed during monthly governance meetings with the host provider.
- See information under this sub-heading in the outpatients section for main findings.

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

- The service manager told us there was a strict criteria for who would be operated on at this location. Patients who required sedation during their procedure or required the procedure to be conducted under a general anaesthetic and patients who would not be able to remain still and comply with instructions would not be operated on at this location.
- Staff from the service had completed basic life support training. This provided staff with a level of skill to manage a deteriorating patient in the immediate deterioration period until further assistance was provided. Staff from the host provider had been trained to a higher level of life support training and would therefore assist the staff until further help arrived.
- Patients had observations taken before, during and after their procedures. Staff from the host provider conducted these observations. We did not observe the use of early warning scores (EWS) for these observations. The EWS system was designed to enable staff to recognise and respond to acute illness, clinical deterioration and to seek appropriate medical assistance. However, we did observe a staff member from the host provider escalating a patient to the staff from the service due to an increase in their blood pressure despite not using a recognised scoring system.

Good

Surgery

- The service used the cataract specific five steps to safer surgery document, which was adapted from the original World Health Organisation (WHO) surgical safety checklist. The host provider audited this and the results of the audit shared with the staff from the service. The most recent audit shared with the service was for July 2017 and demonstrated 100% compliance.
- During our unannounced inspection, we observed variable compliance with this checklist and records we reviewed did not demonstrate consistent use of the checklist. We reviewed eight sets of notes that contained a WHO checklist. One set of notes had a fully completed WHO checklist within it, two had a checklist with no sign in or sign out recorded and the remaining five had a checklist with the sign out section not completed. We escalated this to the service manager.
- If staff from the host provider required medical assistance for a patient following their procedure, they would contact the staff from the service who would come to review the patient. If this staff member could not immediately respond, there was a service level agreement (SLA) in place for the medical officer who worked for the host provider to provide assistance.
- If a patient failed to recover appropriately following their procedure or experienced complications during their procedure, there was a SLA in place to transfer the patient to the local acute hospital.
- See information under this sub-heading in the outpatients section for main findings.

Nursing and support staffing

- The host provider employed all nursing staff and support staff where the surgery took place.

Surgical staffing

- The surgeons were employed under practicing privileges. Two main surgeons completed lists at this location.
- All patients were operated on under day case conditions. There were no requirements for either of the surgeons to complete an on call duty or attend the location within 30 minutes. If a patient had concerns, there was a 24-hour call line, which they could call. A duty manager would answer the call and contact a clinician immediately for advice if the call related to any clinical concerns.
- See information under medical staffing in the outpatients section for main findings.

Emergency awareness and training

- Staff from the service adhered to emergency policies and procedures from the host provider. All staff were given and orientation and local induction to the theatre environment when they started to work for the service. This local induction and orientation included specific information about fire safety and evacuation.

Are surgery services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- Staff adhered to the policies and procedures of the host provider whilst operating on patients in the theatre environment.
- We found pre-operative assessments for patients undergoing cataract surgery were based on the recommended assessment criteria from the Royal College of Ophthalmologists Cataract Surgery Guidelines (2010).
- At the time of our inspection, there was no policy in place for the recognition, diagnosis and management of sepsis. The provider forwarded a draft policy for sepsis management, which was going through the internal ratification process.
- See information under this sub-heading in the outpatients section for main findings.

Pain relief

- The cataract pathway had prescriptions embedded within them for analgesia (pain relief) if the patient required this. The staff from the service would sign to authorise this prescription if it was deemed necessary.

- Staff from the host provider who cared for the patients post operatively told us they would contact the staff from the service for additional pain relief if this was required. If the staff member could not immediately authorise this, there was a SLA (service level agreement) in place, which authorised the medical officer from the host provider to prescribe analgesia if this was required.
- All patients were asked if they were experiencing pain before they left the operating theatre department and this was documented in their notes.

Nutrition and hydration

- Patients were offered drinks and biscuits post operatively by the host provider before they were discharged.

Patient outcomes

- The service had started to collect data on the outcomes of patients who underwent cataract surgery. This was compared with national results to provide other interested providers and clinical commissioning groups (CCGs) with information on the services performance. The outcomes showed the service was achieving their internal target of 85% of patients achieving their target refractive outcome for all months apart from August 2017 where 65% of patients achieved their target. The report did not explain the dip in outcomes.
- The service did not submit data to the Royal College of Surgeons, Patient Reported Outcome Measures (Q-PROMS) for blepharoplasties. This was a self-assessment of the patients' quality of life and how this was changed by surgical intervention.
- The clinical director completed a local cataract audit for the service. Overall, the results were positive with 95% of patients reporting improved vision post procedure, which the auditor recognised, was good compared to professional standards reported nationally. Feedback was given to all surgeons involved in the audit as well as general learning points for all. However, limitations and areas of variable practice were recognised. There was no date noted for all actions to be completed by and no period given for next audit.
- The service recorded all complications for cataract surgery, including posterior capsular rupture (PCR). Information provided by the service showed two cases of PCR from August 2016 to August 2017. This gave the service a PCR rate of 0.5%. This was better than the national benchmark figure of 2%.
- There were no unplanned returns to theatre or unplanned readmissions in 28 days during the reporting period of April 2016 to March 2017.

Competent staff

- Assurance on the competence of the staff from the host provider was gained during monthly governance meetings. The host provider had also started to share documents to give the service further assurance around staff competence.
- Staff told us they had not received formalised sepsis training from the service yet, although this was something they were planning to complete (no date was given at the time of inspection). This was not something, which staff considered a common complication from ophthalmic surgery, however acknowledged the seriousness of this and that all clinical staff should undertake training.
- See information under this sub-heading in the outpatients section for main findings.

Multidisciplinary working

- We observed good multidisciplinary team working during our unannounced inspection between staff from the service and staff from the host provider. Staff told us they thought the team worked well together and were very efficient.

Access to information

- Staff told us they had all the information they required to enable them to provide safe and effective treatment to the patients.
- See information under this sub-heading in the outpatients section for main findings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service manager told us patients who underwent oculoplastic surgery had to observe the two weeks cooling off time in between consultation and procedure. Staff at the service made sure this period was observed in accordance with recommendation 20 of the Review of

Good

Surgery

the Regulation of Cosmetic Interventions. All patients were given written information for them to consider during this cooling off period to enable them to make sure the procedure was right for them.

- Staff told us they had not experienced any patients attending for a surgical procedure who had a do not attempt cardiopulmonary resuscitation (DNACPR) order in place. However, if a patient did have this in place, this would be highlighted on the booking form and appropriate checks made before surgery.
- See information under this sub-heading in the outpatients section for main findings.

Are surgery services caring?

Good

We rated caring as **good.**

Compassionate care

- We spoke with five patients about the care they received during the surgical phase of their care and treatment. All patients spoke positively about the care they had received from the staff from the service. All five patients told us they would recommend the service to their friends and family. One patient stated they would not change anything about the care they received, with another comment from the comment cards stating they were impressed with every stage of their care, especially the theatre stage.
- We observed staff treating patients in a dignified and respectful manner in both the day case area and in the theatre environment. Staff ensured that the patient was kept involved in every step of their procedure and gave them the opportunity to ask questions.
- The service did not produce separate friends and family test results for patients who underwent surgery. The results collected reflected the thoughts and views of patients for the whole service.
- We observed pre-operative checklists being completed for patients in the ward area behind a curtain, whilst a number of other patients were sat the other side. Although staff tried to keep the level of their voices to a minimum, we were not assured that patient confidentiality was being maintained as we could over hear what was being discussed between the staff and patients.
- See information under this sub-heading in the outpatients section for main findings.

Understanding and involvement of patients and those close to them

- Staff made sure all patients understood the post-operative instructions prior to leaving the day case environment. This ensured that all patients were discharged in a safe manner.
- Staff encouraged relatives and carers to be part of the patients care post-operatively. They made sure not only the patient, but also those who would potentially be involved in caring for them after their procedures understood essential information. They also encouraged relatives and carers to ask questions about anything they did not understand.
- We observed all staff involved in the patients care and treatment introducing themselves and explaining their roles and responsibilities.

Emotional support

- We observed staff providing emotional support and reassurance to patients' pre and post their surgical procedure. We observed staff reassuring a patient in a sympathetic way because they were feeling nervous prior to their procedure.

Are surgery services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- The host provider was responsible for the facilities and premises where surgical care and treatment took place. Monthly governance meetings provided assurance to the service on the suitability and appropriateness of the facilities.

Good

Surgery

- The service worked with two main clinical commissioning groups (CCGs) to plan and deliver a range of ophthalmic services to patients. The service had also started to work with another provider of ophthalmic services to offer an even wider range of services to patients.
- See information under this sub-heading in the outpatients section for main findings.

Access and flow

- From July 2016 to June 2017 there were 46 procedures cancelled for non-clinical reasons, which included faults with the theatre and staff sickness from the host provider. The service manager explained these cancellations occurred on two occasions and was beyond the services control. Of these cancellations, all 46 were rescheduled well within 28 days.
- Pre-operative assessments were conducted in the outpatient department during their initial consultation. If the consultant identified that surgery was required, it was completed at the same time as their initial consultation to avoid bringing patients back again.
- Patients were given an appointment for post-operative review between two and four weeks after the procedure. If there were any problems and further surgery identified, this would be arranged at this appointment. If a patient experienced complications post operatively which required urgent surgical intervention, patients were directed to attend their local acute hospital.
- The service only operated on patients under local anaesthetic. If a patient required sedation or a general anaesthetic for their surgical procedure, they would be referred to a local acute hospital. There was no other inclusion or exclusion criteria for this service, patients referred to the service would be reviewed on an individual basis for suitability of surgery at this location.
- The surgeon involved in the patients care and treatment completed the post-operative instructions at the end of the surgical procedure. This was communicated with a nurse from the host provider who discharged the patient once satisfied with their clinical condition.

Meeting people's individual needs

- The service identified at initial consultation if additional services were required to meet patients individual needs during their day case admission. If additional services were required, the host provider would then arrange for this to be provided.
- The service had processes in place to arrange for district nurses to visit patients and help with administration of essential eye drops after surgery if difficulties were identified prior to the procedure. A staff member told us about a recent experience of arranging this, although acknowledged they did not have to do this very often.
- There was a room designated for spiritual and pastoral support within the hospital, which was maintained by the host provider. Patients under the care of the service we were inspecting had access to this room if they required support.
- See information under this sub-heading in the outpatients section for main findings.

Learning from complaints and concerns

- During the unannounced inspection, we did not observe any posters or leaflets advising patients how to complain to the service if they experienced unsatisfactory care and treatment.
- Any complaints received by the service, which also included the host provider, would be shared with them at the monthly governance meetings. Combined investigations would be completed if there was a requirement, and a combined response would be prepared if required. We saw minutes of these meetings which showed complaints was a standing item on the agenda.
- See information under this sub-heading in the outpatients section for main findings.

Are surgery services well-led?

Good

We rated well-led as **good.**

Leadership / culture of service related to this core service

- Staff told us the positive culture extended through to this core service and remained patient focused. The service manager remained the overall leader for this part of the service, although the surgeon would be accountable for the patient during their treatment. Staff told us the service manager was visible and approachable.
- Staff from the service worked alongside staff from the host provider in the surgical setting. Staff told us this relationship had strengthened since the service manager was employed, and now there was a positive culture and high morale amongst them. Staff now felt like there was one big team all working towards a common goal, which was to provide the best care and treatment for the patients.
- See information under this sub-heading in the outpatients section for main findings.

Vision and strategy for this core service

- There was no specific vision or strategy for this core service. Staff followed the same vision and strategy that was in place for the whole service.
- See information under this sub-heading in the outpatients section for main findings.

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

- Staff from the service had monthly governance meetings with the host provider who supplied the theatre provisions to discuss their working relationship and areas, which influenced the quality of the service provided. This included incidents and complaints, which impacted on both services, audit results and referral rates for the service. Any concerns raised at this meeting were taken forward to the services internal governance meetings.
- The service adhered to the National Safety Standards for Invasive Procedures (NatSSIPs), which set out the key steps necessary to deliver safe care for patients undergoing invasive procedures. We observed a pre list safety brief and completion of the World Health Organisation (WHO) checklist; all staff were fully involved and engaged with all of the process. WHO checklist audits were completed by the host provider, however results of these had only just started to be shared with the service manager and therefore assurance of compliance could not be assured.
- The service had implemented an immediate feedback initiative for the surgeons to complete after their lists (Medical Advisory Committee (MAC) minutes, April 2017). The service manager told us this was implemented to identify any immediate issues, which senior managers needed to be aware of. This was not in place of incident reporting or any other processes in place to ensure safe care and treatment. So far, this initiative had only identified one issue at this location, but the input from this one issue had identified a need for more detailed pre-admission screening.
- See information under this sub-heading in the outpatients section for main findings.

Public and staff engagement

- The services public and staff engagement processes have been reported on under the outpatient service within this report.

Innovation, improvement and sustainability

- The service had implemented a text messaging service with the surgeons to identify any urgent matters for escalation. The service manager told us this was not to replace any existing systems to escalate concerns; however, this was a method to improve on the existing systems and improve communication with the senior managers.
- See information under this sub-heading in the outpatients section for main findings.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

The main service provided was outpatients and diagnostic imaging. Where our findings on outpatients and diagnostic imaging for example, management arrangements also apply to other services, we do not repeat the information but cross refer to the outpatient and diagnostic imaging section.

We rated safe as **requires improvement.**

Incidents

- There were no never events reported for the service from April 2016 to March 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were no serious incidents reported for the service from April 2016 to March 2017. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.
- The service recorded 16 incidents from April 2016 to March 2017. Of these, one was classed as a clinical incident with no harm and the remaining 15 non-clinical incidents. Twelve non-clinical incidents occurred in the outpatient department. There was no evidence of any themes or trends.
- There was an integrated governance policy, which contained a section on incident reporting which was dated April 2017. All staff we spoke with were aware of this policy and were confident on the incident reporting process.
- Staff told us they received feedback about incidents they had reported after a full investigation had taken place.
- There were monthly local governance meetings held where learning from incidents was part of the structured agenda. We saw evidence of learning from these meetings. We were also told that senior governance staff shared a bitesize newsletter with all staff in the organisation, which also had incidents contained within them and the learning that had occurred during the investigation process.
- We reviewed an example of a root cause analysis (RCA) which was conducted for an incident graded no harm. There was evidence of multi-disciplinary input into the report, root causes were identified and action plan produced which had identified owners of each action and a date for completion. This reflected a positive approach to investigation and learning from incidents.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in

relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred. Staff understood their responsibility under the duty of candour and we saw evidence of when the duty of candour had been implemented.

- Staff we spoke with had an understanding of the duty of candour process and the need for being open and honest with patients when errors occur. Senior staff members were able to confidently explain the process they undertake when implementing the duty of candour and gave examples of when they had to complete this.
- The monthly service pack, which was submitted to the clinical commissioning groups (CCGs), provided details of any duty of candour breaches experienced at the service. From April 2017 to August 2017, there had been no breaches recorded.
- The complaints policy included the principles of duty of candour and included a template letter, which was sent to patients who complained. Although included in the complaints policy, staff told us they would extend the duty of candour process to any incident where errors had occurred. Staff would be open and transparent with their approach to investigations and offer an apology to the patient involved.
- The RCA that was provided by the service demonstrated the principles of the duty of candour. We saw evidence of staff being open and honest with the patient around the nature of the incident.

Cleanliness, infection control and hygiene

- The outpatient department was visibly clean and tidy at the time of our inspection. Staff told us the host provider was responsible for the cleaning of the environment. If there were any complaints regarding the cleaning, they would escalate this to the host provider.
- Daily cleaning sheets were displayed in the outpatient department, these were signed when completed.
- The service had an infection prevention and control policy, which was in date and had a review date. All staff were aware of where to locate this policy.
- There were handwashing facilities within the clinical environment and staff had access to alcohol hand gel at point of care. We observed staff performing hand decontamination in accordance with the World Health Organisation (WHO) five moments for hand hygiene. We also observed hand hygiene promotional posters to support compliance with hand hygiene.
- Each staff member had been assessed for compliance with good hand hygiene principles. The service were in the process of starting monthly hand hygiene audits, which would be based against the five moments for hand hygiene. There were no audits completed at the time of inspection.
- An infection prevention and control audit of the outpatient environment showed they were mainly compliant for all aspects apart from knowledge about inoculation injuries and displaying information about how staff should self-manage an inoculation injury. During our inspection, we saw there were posters displayed which advised staff on the correct procedures for dealing with an inoculation injury.
- There were wipes available for decontaminating equipment after use. We observed staff wiping down equipment after this had been used to prevent the potential transmission of infection between patients.
- Staff had access to personal protective equipment (PPE) in the outpatients department to protect themselves and patients during care and treatment.

Environment and equipment

- The outpatients department for the service was located in the corner of the main outpatients department for the host provider. There was a sign on the door to identify this was the service's outpatient department.
- Staff in the outpatient department had access to a resuscitation trolley in the event of a medical emergency. All equipment on the trolley was checked and maintained by staff from the host provider. We reviewed the trolley during our inspection and found it was signed as being checked regularly and items were in date. The trolley itself was sealed and tamper proof.
- Emergency buzzers were available in all three clinical rooms within the department. These buzzers were checked as part of a list of daily checks performed by staff.

Good

Outpatients and diagnostic imaging

- The room where the class four laser was operated did not have a sign in place, which identified to others when the laser was operated. This was on the service's risk register as a high risk as this did not comply with the Health and Safety (Safe Signs and Signals) Regulations 1996 (11) and associated standards. Staff used a laminated 'do not enter' door sign to identify when laser treatment was being administered as a way of mitigation. We did not see this in use on the day of inspection, as no laser treatments were administered. On the unannounced inspection, the service manager told us this had been escalated and an engineer had been to review the department about this. Information provided after the inspection supported this.
- An external laser specialist performed annual servicing and maintenance work on the class four laser equipment. Operatives who were assessed as competent to use the equipment conducted routine function testing. We saw evidence of recorded routine functions tests which had been conducted.
- The service had a laser user administration guidance document (also known as local rules), which was dated and provided staff with information on safe working with the class four laser. However, senior staff told us they had no supervisor on site that would ensure that all staff were adhering to this guidance and ensuring a safe environment.
- There was a safe system in place for the 'fire' key for the class four laser. Only those members of staff authorised to use the equipment could access this key.
- Safety equipment was available for staff to use during procedures where the class four laser was used.
- One of the rooms within the department was also used as a treatment room where minor procedures were carried out. All procedures were conducted in this environment were in accordance with professional standards. Procedure conducted in this room included posterior capsulotomy to remove cloudiness following a cataract procedure, removal of sutures, excision of minor lesions and removal of foreign bodies from the eye.
- All equipment in the outpatients department had evidence of in date electrical safety tests.
- We observed staff correctly segregated clinical and domestic waste. Waste bins provided for the department were enclosed and foot operated. Sharps bins were correctly assembled and below the fill line. The management and disposal of sharps and waste was completed in accordance with policy.

Medicines

- There was a medicines management policy dated April 2017 with a review date recorded as April 2018. Staff were aware of this policy and had access to this on their electronic system.
- Patients were not routinely prescribed medicines to take away with them in the outpatient department; the consultants would include any changes to medications in letters to the GP for them to supply. If medicines were however required, there were processes in place for pharmacy support by the host provider.
- Nursing staff in the outpatients department administered local anaesthetic and dilation eye drops under a patient group direction (PGD). A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.
- Staff checked and recorded the temperature of the medicines refrigerator each working day. They recorded only the highest and lowest temperature, with no actual temperature reading recorded. We asked staff what the acceptable temperature range was for the refrigerator; however, they gave an inaccurate higher temperature of 10 degrees. The service's own policy and medicines stored within the refrigerator both gave a range of between two and eight degrees.
- We were not assured that all staff would know what action to take if they identified the refrigerator temperature was outside of its acceptable range. One staff member told us they would report the fault to the company responsible for the maintenance of the refrigerator; however, they failed to indicate what they would do with the content of the refrigerator in this instance. With further prompting, they eventually told us they would ask the pharmacy staff from the host provider to store any items.

- At the time of our inspection, we found the medicines refrigerator was locked as per the policy.

Records

- All records for patients referred directly to the service were stored securely on site. Records for patients reviewed by the service but were under the care of the host provider were stored in the host provider's records department. On the day of their appointment, the host provider would liaise with the service to get the records to them in time for the appointment.
- Patients who were seen for cataract or oculoplastic complaints had pre-prepared pathways for documentation, which all staff members completed. For patients attending the department for other ophthalmic conditions, staff would document on routine documentation sheets.
- The service had a register of authorised users for the class four laser. The user maintained appropriate records each time after the laser was operated. We saw these records, which were stored in the room where the laser was operated.

Safeguarding

- The service had a safeguarding vulnerable adult's policy and a safeguarding children policy both dated March 2017.
- The service had a lead for safeguarding and all staff were aware of who this was. The lead for safeguarding had level three for safeguarding children. Further expert advice was obtained through contacting the local authority safeguarding teams.
- The service provided all staff with safeguarding adults training. This was split into two parts with all staff completing part one and clinical staff completing part two training.
- Staff at the service did not treat children at this location, however on occasions children would accompany patients. All staff were required to complete level two safeguarding children training. At the time of our inspection, staff were unsure what level of training they had completed and could only evidence they had completed level one training. Senior staff members confirmed all clinical staff should be trained to level two in children's safeguarding as indicated in the intercollegiate guidance. Training records provided by the service demonstrated all clinical staff were in date for safeguarding level two training.
- Staff told us they felt confident in identifying and reporting potential safeguarding concerns, and gave examples of when they had done this. Staff members received positive feedback from senior members of the service and local authority on the occasions when they had escalated their concerns.
- Additional training for staff had been provided on the subjects of female genital mutilation (FGM) and prevent training. This provided staff with additional knowledge for protecting patients and the public from harm and abuse.

Mandatory training

- All staff at the service were required to complete conflict resolution, equality, diversity and human rights, fire safety, health, safety and welfare, information governance, moving and handling loads, safeguarding adults part one, safeguarding children level one and basic life support.
- All clinical staff were required to complete additional training in infection prevention and control, moving and handling patients, safeguarding adults part two, safeguarding children level two, consent, dementia awareness and female genital mutilation (FGM).
- At the time of inspection, all staff directly employed by the service were in date for their mandatory training.
- We reviewed the files of two doctors employed under practicing privileges. One of the doctors were in date for all items of mandatory training, however the other doctor had no documented evidence of completing any mandatory training. This was escalated to the service manager at the time of the inspection who contacted their human resources (HR) team to rectify this. The service manager was assured copies had been provided previously, however had yet to be uploaded on to their HR file.
- The HR department were responsible for updating training files when training was completed and would inform a staff member when they were due to complete their training again. The service manager had created

their own database to monitor compliance with mandatory training. This database did not include staff who worked under practicing privileges or employed through a bank or agency.

Assessing and responding to patient risk

- The outpatients department was compact and the clinical rooms had multiple items of equipment contained within them. The service manager had conducted a fire risk assessment of the department; however, we were not assured that this had taken into account the manoeuvrability of patients who had mobility difficulties and may be in wheelchairs as well as equipment which was contained within the rooms. Staff told us it was difficult to arrange the clinical rooms so patients in wheelchairs could enter and leave them due to the equipment contained within them.
- Staff completed WHO surgical checklists in the outpatient department for patients who underwent a minor procedure. The National Patient Safety Agency (NPSA) issued a patient safety alert recommending that all providers of surgical care use the WHO Surgical Safety Checklist. This was incorporated into the '5 Steps to Safer Surgery' which included pre-list briefings, the steps of the WHO Surgical Safety Checklist and post-list debriefings in one framework. The checklist focused the whole team on the safety of practices before, during and after a procedure.
- The service had not audited their compliance with the WHO surgical safety checklist so we could not be assured this process was embedded within the department. We did not observe any minor procedures being conducted in the outpatients department during our inspection.
- The service had policies and procedures in place for identifying a patient who was suffering from a myocardial infarction (heart attack), stroke or fainting attack. Staff we spoke with were confident in the immediate management of these types of deteriorating patient.
- The service had a service level agreement (SLA) in place in the event of a deteriorating patient. If patients became unwell during their appointments, staff would organise a transfer to a local acute hospital. If there were indications that the patient was suffering from an ophthalmic emergency, staff would transfer to the patient to the nearest acute ophthalmic specialist hospital. No patients had been transferred out under this SLA since the service was registered.
- Staff told us if they had concerns about a patient after their outpatient consultation, which could affect their surgery; they would consult with staff from the host provider for advice on additional risk assessments. Examples of where this would happen included manual handling risk assessments or falls risk assessments. However, this had not happened up until the time of inspection.

Nursing staffing

- The service did not directly employ nursing staff at this location; however, they used regular bank nurses for outpatient clinics, which ensured consistency within the department.
- The service directly employed three healthcare assistants (clinic assistants) in the outpatients department. The service also employed an administrative assistant who was key to the routine running of the outpatient clinics.
- Staffing for an outpatient clinic was one clinic assistant, one nurse and one receptionist. Staff told us if the clinic assistant or nurse phoned in sick, an attempt to replace them from the bank of staff they used would be made. If the receptionist reported sick, the team leader or service manager would cover their duties.
- Information provided showed no evidence of staff sickness concerns at the service from April 2016 until the time of our inspection.

Medical staffing

- Patient care was consultant led, there were two consultants regularly working at this location, however five consultants were employed under practicing privileges. Consultants who ran the clinics would be on-site until all patients had left the department.
- Staff told us if one of the consultants reported sick, they would attempt to get a replacement for the day however due to limited consultants who were orientated to the service, it would be unlikely to replace them at short notice.

Good

Outpatients and diagnostic imaging

- The service did not employ any Registered Medical Officers in the outpatient department.

Emergency awareness and training

- Staff at this service relied upon the business continuity plans for seasonal fluctuations, and the impact of adverse weather and disruption to staff from the host provider. We saw copies of these policies during our inspection.
- All staff told us they were aware of the risk fire posed to the service. The host provider devised the fire safety policy and staff from the service followed this. Staff told us they had recently taken part in a fire evacuation drill, which was coordinated by the host provider.
- In the event of a major incident being declared, staff from the host provider would direct staff from the service in the actions they should take.
- Staff were unsure if all equipment, especially the class four laser in the outpatient department would operate in the event of a power cut, as there were no power sources identified as those connected to a back-up generator and no previous tests had been conducted. Information provided after the inspection showed the class four laser was not connected to the back-up generator. This therefore meant the laser would not fire in the event of a power cut and there would be no harm to the patient.

Are outpatients and diagnostic imaging services effective?

We rated effective as **not rated.**

Evidence-based care and treatment

- We reviewed policies, procedures and guidelines produced corporately for the service to implement locally. These were all based on current legislation, evidence-based care and treatment and best practice, which included policies and guidance from professional organisations such as Royal College of Ophthalmologists and National Institute for Health and Care Excellence. Staff could access these documents on their electronic system and had paper copies of some of the key documents they used.
- The service reviewed relevant and current evidence-based guidance, standards, best practice and legislation at the Medical Advisory Committee (MAC) meetings. We reviewed minutes from these meetings, which supported this.
- The service participated in research, which would inform future evidence-based care and treatment. All proposals were reviewed and discussed in the MAC meetings before a decision whether to participate was made.
- The audit programme was devised corporately and cascaded down through the service manager. All staff participated in auditing of the service and results discussed at local governance meetings. For more specialist audits including the cataract audit and glaucoma audit, this was delegated to a suitable clinician to complete. Local audits included infection prevention and control audits, equipment audits and information governance toolkit audits.
- The service had printed copies of key documents from the host provider, which they were required to work alongside. During our inspection, we found these documents were out of date and highlighted this to senior staff members. Staff did not have access to the host providers electronic system so did not have access to the updated versions of the documents. On the unannounced inspection, we found these documents had been updated with the most current version.

Pain relief

- Staff told us patients did not usually experience pain or discomfort within the outpatient department, however if a patient did experience pain following a minor procedure, there were systems in place to obtain analgesia (pain relief) for the patient if they required it.
- Staff did not routinely complete audits on the effectiveness of analgesia, as most patients did not require analgesia whilst in the department.

Nutrition and hydration

- Food and drink was not provided to staff in the outpatients department, however patients had access to vending machines, a water fountain and a coffee shop in the immediate vicinity of the department.

Patient outcomes

Good

Outpatients and diagnostic imaging

- The service collected regular patient outcome information as part of a monthly return which the clinical commissioning group (CCG) required as part of the contract. Recent feedback from a meeting with the commissioners however identified further patient outcome data was required to be collated by the service.
- Patient recorded experience measures (PREMs) and patient reported outcome measures (PROMs) were set by the CCG and reported on monthly by the service. Information provided by the service showed mainly positive experiences and improvements after receiving care and treatment. Out of the 18 questions which patients were asked, only two questions received a neutral response overall from patients, this was in relation to patients handling their health problems differently and them experiencing fewer health problems. All patients felt they were well taken care of.
- The service did not participate in national audits and therefore could not benchmark their outcomes against other national services. However, when the current service manager began with the service, they locally benchmarked their service using routine outcomes, which were gathered locally.
- The service conducted local audits to monitor their own internal performance. The results of these audits were disseminated internally on the balanced scorecard and the services own weekly performance report.
- Information provided before the inspection identified glaucoma audits as an area of local audit. However, after requesting results of these audits, the service was unable to provide them, as they do not see many patients with glaucoma at this location.
- See information under this sub-heading in the surgery section for main findings on patient outcomes.

Competent staff

- Appraisals were completed annually. At the time of our inspection, all staff employed by the service had an in date appraisal. We also saw copies of appraisals for staff employed under practicing privileges in staff files. Staff told us appraisals were meaningful overall, however some staff had identified during their appraisal they would like to develop their roles further but this had not yet happened.
- We reviewed six staff files during our inspection and found three staff had all required documents including disclosure and barring services (DBS) checks, photographic proof of identity, evidence of continual professional development, two references, and evidence of professional registration where applicable and health questionnaires. At the time of our inspection, the human resources department were also able to provide the required documentation for another member of staff.
- The two remaining staff files were for bank staff and they did not include health questionnaires, evidence of professional registration and references from a previous employer. The NMC states an employer must ensure all nurses are registered before they begin employment, which must be regularly checked throughout the time they are employed. We checked and verified at the time of inspection that both nurses were registered with the NMC.
- Only consultant ophthalmologists were authorised to operate the class four laser, in accordance with local safety rules. All consultants who worked at the location had evidence of authorisation to use the equipment following competency assessments.
- The service had a procedure in place for managing staff with poor or variable performance. Information received showed one member of staff had been suspended and one member of staff had their practicing privileges removed due to poor performance.
- The service manager told us they would contact the employer of any staff member employed under practicing privileges if there were concerns over their performance; however, they did not have a process in place where they would be informed if there were concerns at their regular work place.
- We saw evidence of revalidation for two of the consultants who regularly completed work at the location under practicing privileges. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up-to-date and fit to practice.
- Both consultants were registered with the Royal College for Ophthalmologists and only conducted procedures they were trained and competent to perform. Only one consultant who worked at the service under practicing

privileges was authorised to conduct oculoplastic procedures. The service manager told us this consultant regularly performed these procedures in their usual place of employment. References provided for the staff member and evidence which formed part of the staff members' revalidation provided evidence of competence for these procedures.

- The arrangements for granting and reviewing practicing privileges were conducted corporately. We saw evidence of the reviewing and granting process in the medical advisory committee (MAC) meeting minutes.
- The service had a laser protection supervisor (LPS) who had been appointed into this role following successful competency training and assessment by the corporate laser protection advisor (LPA).
- No staff had received sepsis training through the service at the time of our inspection.

Multidisciplinary working

- During our inspection, we observed staff working well together to assess and plan ongoing care and treatment for patients.
- When staff from the host provider delivered care out of the services outpatient department, we saw well-coordinated care and treatment, with external staff members commenting on how they enjoyed working with the team in the outpatient department.
- Optometrists worked in the outpatient department to provide specific clinics for patients under practicing privileges. At the time of inspection, there were no optometrist led clinics running.

Access to information

- The service had an electronic system in place, which enabled them to communicate with patients GPs in a timely manner following their appointments. Letters following the patient's appointment were sent the same day. This enabled GPs to update their systems in a timely manner and amend any prescriptions if required. The service were able to internally monitor this system and pull of audit data to demonstrate timely communication.
- All staff had access to the services electronic systems, which contained all the services policies, procedures and guidelines. This included staff who worked under practicing privileges and those working on a bank contract. The staff however did not have access to the electronic systems of the host provider and therefore relied on paper copies of any key documents.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff were aware of the requirements for gaining consent from patients. Records provided by the service showed 100% compliance with consent training.
- All patients undergoing a cataract procedure were given an information booklet to support the information given to them by the staff at the service. Within this document was also a copy of the consent form, which informs them of the common complications, serious risks and alternatives to the surgery. Staff in charge of the patients care found this enabled patients to retain the information better about these implications of the surgery and supported the consenting process on the day of surgery.
- Staff had a good understanding of the Mental Capacity Act (2005) and were confident in identifying patients who required capacity assessments. Staff were able to give examples when they had identified concerns around a patient's capacity and escalated this to the consultant in charge of their care who performed an assessment.
- Information provided by the service showed 83% of staff had completed Mental Capacity Act (2005) training.
- For patients who lacked capacity to make decisions about their care and treatment, staff used an alternative consent form called a consent form four. If the patient had a lasting power of attorney for medical decisions, staff would ensure appointments were scheduled to enable them to attend with the patient.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

Good

Outpatients and diagnostic imaging

- During our inspection of the outpatients department, we spoke with three patients and one relative about their experience with the service. We also received five comment cards about the service. All feedback about the service was positive with comments including friendly staff and an efficient service. All responses indicated they would not change anything about the service.
- The service used the NHS Friends and Family test (FFT) to obtain feedback from patients. The FFT is a single question survey, which asks patients whether they would recommend the NHS service to their friends and family.
- Results for the FFT ranged from 91% to 100% for the reporting period of April 2016 to March 2017; however, the response rate was low between 9% to 29%. The service was aware their response rates were low and were in the process of reviewing how they received this feedback. As patients were given medication to enable specific tests, this affected vision for a duration after the appointment. Staff now gave patients a freepost envelope for them to return their feedback forms to them. This had started to have a positive impact on their response rates.
- The most recent patient satisfaction survey results for August 2017 had 25 respondents. Most respondents were satisfied with the service provided, with additional comments made around the helpfulness of staff, calmness and relaxed feeling at the location and the general professionalism of all staff members. There were two negative responses made around the waiting time for appointment and misinformed about driving post appointment, however generally the feedback was positive.
- All patients told us staff maintained their privacy and dignity at all times when they were providing care. During our inspection, we followed through a patient on their outpatient pathway. We observed their privacy and dignity being maintained at all stages and the patient was treated with respect.
- We observed a thank you card had been sent to the staff at the department, which thanked all the staff for their compassionate care and treatment during their pathway.

Understanding and involvement of patients and those close to them

- We saw staff taking the time to explain all the details of their care and treatment to patients and encouraged them to be partners in their care. Staff communicated with patients in a manner they understood.
- Staff made sure patients had the opportunity to ask questions about their care and treatment during and after their consultation. Patients told us they felt comfortable and confident when asking staff for further information about their care and treatment.
- We also saw staff encouraging relatives and those close to the patient to be involved in the patients care and treatment and ensured they had understood the information provided.
- Patients were given information of who to contact if they had any concerns about their care and treatment, or if they needed to clarify further appointments.

Emotional support

- We observed staff actively approaching patients after their appointments to make sure they had no concerns following their consultations and offering support if required.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- The service worked with two main clinical commissioning groups (CCGs) to plan and deliver a range of ophthalmic services to patients. The service had also started to work with another provider of ophthalmic services to offer an even wider range of services to patients.
- The service also had a sub-contract with another provider to plan and deliver ophthalmic care and treatment for patients.

Good

Outpatients and diagnostic imaging

- The outpatients department for the service was located within the larger outpatients department of the host provider. Once the patient had attended the reception for the service, they were directed to wait in the same area as patients for the other outpatient department.
- Main reception staff for the host provider directed patients on arrival to the service outpatient department. Outside of the outpatient department were signs to identify the service; however, these were not immediately visible from the main reception of the hospital.
- We observed staff discussing possible transportation methods with patients that they could use to make their appointments. For those who drove to the service, all patients we spoke with told us there were adequate amounts of parking at the location.
- Services were mainly provided in core weekday hours; however, the service had the flexibility to provide evening and weekend appointments if there was a requirement.

Access and flow

- From July 2016 to June 2017, all patients were seen within eight weeks of referral except for March 2017 and June 2017 when 98% and 93% of patients were seen within eight weeks of referral. This was better than the target set by the CCG of 85%.
- The service manager told us they aimed to complete treatment within 12 weeks. The service aimed to have a patient seen within four weeks, the operation completed within the next four weeks and then a follow up within the final four weeks.
- Patients who were direct referrals to the service were given a choice of appointment dates and times. Patients who received care at the service referred from an outside provider had their appointments managed by that provider.
- The service had a process in place to manage patients who did not attend (DNA) their appointment. Staff would attempt to call the patient to make sure there were no immediate concerns behind their failure to attend their appointment and a new appointment made. If the patient DNA for three appointments, they would be discharged from the service and notification to the GP, opticians and CCG would be sent.
- The monthly service pack, which was sent to the CCGs, contained monthly details on the numbers of DNA and short notice cancellations experienced at the service. The service had relatively low number of DNA or short notice cancellations for appointments. Information provided for April 2017 to August 2017 showed a maximum of two patients DNA or short notice cancelled their appointments each month.
- There were no delays in the clinics that were running on the day of our inspection. Staff told us if there was a delay, they would explain the situation to the patient and keep them updated.

Meeting people's individual needs

- Staff had access to a telephone interpretation service for patients whose first language was not English. All staff were knowledgeable about how to access this; however, staff told us they rarely used this. Patient information leaflets were only available in English or braille at the time of our inspection; however, staff told us they were in the process of sourcing them out for the service.
- The service had a dementia strategy in place, which identified aims and objectives to improve care given to patients who were living with dementia. Staff had received training on caring for patients living with a dementia.
- There were services available within the outpatient department for patients with hearing difficulties, for example a hearing loop. We also observed staff speaking slowly and clearly to one patient with hearing difficulties so they were able to lip read.
- There were no services immediately available for meeting the needs of a patient with a learning disability. However, staff told us if they had a patient with a learning disability, they would assess the patients' needs during their consultation and plan for future appointments. Staff also told us they would encourage any relatives or carers to accompany them to appointments.
- Patient information leaflets on common eye conditions and the information given to patients on the cataract pathway were compliant with the NHS accessible information standards. This was provided on different coloured paper (usually yellow in colour), in large font or in braille.

Good

Outpatients and diagnostic imaging

Learning from complaints and concerns

- The service had received seven complaints from April 2016 to March 2017. Two of the complaints were about staff attitude and behaviour; one was in relation to confidence in the doctors' diagnosis and a fourth one was about an appointment time change on the day of appointment. We did not have the details for the other three complaints.
- All complaints underwent a rigorous process to ensure the patients who complained were satisfied with the outcome. Three out of the four complaints had been closed after investigation at the time of our inspection. If there were learning opportunities from the complaints, this was shared with all staff.
- No complaints were referred to the Parliamentary and Health Service Ombudsmen (PHSO) during the reporting period of April 2016 to March 2017.
- We observed signs in the department, which informed patients on the procedure to follow if they wanted to raise a complaint. However, in the waiting area immediately outside the outpatients department, there were complaints procedures for patients to follow which provided details of how to complain by the host provider. We raised this with the senior staff who acknowledged this could be confusing for patients; however, there had been only two occurrences of complaints being sent to the host provider in error.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as **good.**

Leadership and culture of service

- Senior managers had the capacity, capability and experience to lead effectively. Staff told us senior managers were visible and approachable, and the outpatient environment had improved since they started.
- Staff told us they regularly saw and had contact with members of the executive team. They told us they felt confident to approach them with issues if they needed to. A senior staff member told us they received regular support and advice on an ongoing basis to develop in their role.
- All staff we spoke with told us they felt respected and valued by their managers and colleagues. Staff enjoyed working at the service and told us they would not still be at the service if they were not respected and did not enjoy being part of the service.
- All changes that affected the service were communicated with all staff. Staff told us communication within the service had improved and this had led to an improved culture within the department.
- Senior managers told us staff well-being and safety was of high importance to them. They told us they made sure the rota was fair for all staff and they had equal time off. A senior staff member informed us of an incident where a member of staff was not getting their time off due to being requested to work at other locations. This affected their work at the service so the senior member of staff had to intervene to ensure the staff member was getting their days off.
- Staff said there was no bullying or harassment within the service and they felt all staff regardless of backgrounds were treated equally. The service had a raising concerns policy, which supported staff to raise a concern in the workplace if this was required. Staff were aware of this policy.

Equality and Diversity

- The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) became mandatory in April 2015 for NHS acute providers that deliver £200k or more of NHS funded care. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. The service manager told us this data was collected and reported corporately, however they were very aware of equality and diversity standards and the protective characteristics. The service had an equality and diversity lead for staff to seek advice from if they had concerns. The registered manager confirmed this information was collected and reported corporately, and they were

waiting for the report to be published to identify if any further actions were required. Following the inspection, the provider sent a copy of the corporate WRES strategy of how they intended to meet this requirement.

Vision and strategy for this core service

- There was a vision and strategy for the service, which all staff were aware of, and progress against this was regularly reviewed at executive meetings.
- A mission statement had been developed for the service, which aimed at making eye care better for all. We saw posters displaying this mission in the outpatient department.

Governance, risk management and quality measurement

- The service had a document which contained terms of reference for all clinical governance meetings as well as demonstrating the governance structure for the service.
- Governance arrangements to monitor quality, performance and safety were in place and provided assurance to the executive board. There were governance meetings at all levels which were held on a regular basis to discuss key issues such as incidents and complaints, risks, best practice guidance, audits and lessons learnt. These meetings were minuted and there was a clear demonstration of information being shared with all staff members from these meetings.
- All local and corporate governance meetings fed into the medical advisory committee (MAC) meetings. We reviewed the terms of reference of these meetings and minutes from the meetings. We found them to be informative and in-depth meetings and reviewed key corporate safety and quality aspects, including reviewing practicing privileges for consultants and optometrists working within the larger organisation.
- The human resources (HR) department was responsible for updating and maintaining staff files, which included items such as health questionnaires, training records, disclosure and barring service (DBS) records, appraisals and professional registration details. During our inspection, we found staff relied on the HR department to update these regularly and rarely made checks to assure themselves that all items were recorded as required. The service manager recognised this was an area where they needed to be more involved.
- There was a corporate policy in place, which required staff to renew their DBS checks every five years. All staff had a DBS, which had been checked in the last five years.
- Consultants working at the service held indemnity insurance in accordance with the HealthCare and Associated Professions Indemnity Arrangements Order 2014. Details of this were recorded within their personal files on the electronic system.
- The corporate head of governance had developed a bitesize governance newsletter, which was distributed to all services. We saw evidence of this newsletter and staff told us they thought this was useful for communicating corporate wide governance issues, which had wider learning. The head of governance also forwarded national safety alerts to the location for them to review and action if applicable.
- The service had a local risk register, which was regularly reviewed at local governance meetings. The service manager and team leader added risks to the register, however all staff were responsible for escalating risks to be added. The service used a red, amber and green (RAG) rating for the risks. Risks, which were identified as high (red) after mitigation, were escalated to the corporate risk register. We saw evidence of the risk register being reviewed regularly and risks closed when resolved.
- We observed nine entries on the local risk register with two remaining a high (red) risk following mitigation. A new operational head of governance had recently identified a way to improve the risk register, which included archiving closed risks so staff could clearly identify which risks were still on going.
- The use of the class four laser was a high risk on the services own risk register due to no illuminating signage. We asked the service to provide evidence of escalation of this risk to the provider risk register; however, we could not identify this exact risk on the copy of the provider risk register dated 31 August 2017. We did however observe the use of lasers and the management of third party facilities on the provider risk register.
- The service manager completed risk assessments where risks in the service were identified, for example a fire risk assessment in the outpatient department.

Good

Outpatients and diagnostic imaging

- The service completed a monthly service pack for the clinical commissioning groups (CCGs). Contained within this document were key outcomes, which they were monitored on as part of their contracts with the CCGs. Regular monthly meetings between corporate staff members and CCGs were conducted to review the returns. The service manager received feedback from these meetings. There were plans for the service manager to attend these meetings in the future.
- There was clear evidence in the governance minutes that auditing was important to the service, with many local audits being conducted. However, there was no evidence of participation in national benchmarking audits. This meant that the service found it difficult to make comparisons in regards to the quality of care they provided compared with other providers. The service manager had however conducted a piece of work when they first arrived at the service to benchmark their performance locally and identify their unique selling point as a preferred service.

Public and staff engagement

- The service actively sought out the views of patients and members of the public on how the service could be improved. They also sought out views of organisations on how they could develop the service during organised engagement meetings. This had led to proposals about service development being submitted to the executive team.
- A corporate wide staff survey was completed annually. Staff at the service told us they had participated in this and results were discussed at the corporate day in July 2017.
- The provider held a 'company day' in July 2017 where 95% of the staff in the organisation attended. During this day staff contributed to the organisations vision and strategy through a series of tasks and events. Most staff at the service attended this company day and found it informative and meaningful.

Innovation, improvement and sustainability

- The provider had recently started to form links with other ophthalmic providers to broaden the scope of care and treatment, which it provided, and aimed to provide a more seamless and streamlined pathway for the patients they saw. The service we inspected had been involved in this initiative and had already looked into ways they could provide a 'one-stop' pathway for patients.
- The service manager had looked into ways they could improve the service and maximise the outpatient capability at this location. The clinics were not currently running to full capacity so they were working on methods to maximise the capacity for this service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that prompt action to address the concerns identified during inspection in relation to the operation of the class four laser and lack of onsite supervisor to ensure safe usage.

Action the provider SHOULD take to improve

- The service should ensure they have regular oversight of all staff files and they assure themselves regularly of the completeness of them.
- The service should ensure any risks escalated to the provider are recorded on the provider risk register.
- The service should ensure all staff adhere to policies and procedures of the host provider when providing surgical care and treatment.
- The service should ensure the sepsis identification and management policy is implemented at the earliest opportunity.
- The service should ensure all staff are aware of the incident reporting process and what constitutes an incident.
- The service should ensure World Health Organisation (WHO) surgical safety checklists are completed for all surgical and minor procedures and audit the compliance of these checklists.
- The service should ensure the fire risk assessment takes into consideration patients with mobility issues.
- The service should ensure all staff are aware of the medicines storage policy and the actions to take when medicines are not stored correctly.
- The service should ensure hand hygiene compliance is regularly audited and actions identified where required to support or improve compliance.
- The service should consider reviewing which relevant national audits can be completed to benchmark the quality of care provided.
- The service should investigate the day case waiting area where patients wait prior for their procedures for potential confidentiality breaches.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not met:** • The room where the class four laser procedures were conducted was unsuitable at the time of inspection and could not be locked. • There was no signage in place which complied with Health and Safety (Safe Signs and Signals) Regulations 1996 (11) and associated standards and guidance. • There was no onsite supervisor who observed the safe usage of the laser and ensured all staff were adhering to the local safety rules. Regulation 12 (1)(2)(b)(d)(e)