Optegra Solent Eye Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Optegra Solent Eye Hospital is operated by Optegra UK Limited. Optegra is part of a nationwide company, which has seven hospitals and three outpatient clinics in the UK. The hospital provides services to adults over 18 only.

The hospital was opened in 2010. It is located on the ground floor of a multi-business development in Whitely, Hampshire. The hospital had five consulting rooms, a reception area, seven diagnostic rooms, three operating theatres (one operating theatre was not in use), a treatment room and pre and post operative areas. The main services provided were ophthalmic surgery and ophthalmic outpatients.

Surgical services provided included cataract surgery, refractive eye surgery, oculoplastic surgeries, retinal diagnostic, general ophthalmic surgical services, and ophthalmic disease management. During the 12 months prior to our inspection, the hospital recorded 1,995 surgical procedures. Of these 50% were for cataract surgery, 13% refractive lens exchange, 9% refractive laser treatments and 28% other procedures including laser procedures to address complications, age related macular degeneration (AMD) injections, retinal procedures, oculoplastic surgeries and glaucoma procedures.

During the 12 months prior to our inspection the hospital recorded 6,658 outpatients appointments with the majority of these patients (65%) seen for follow-up after surgery. Others were seen for an initial consultation with the optometrist or for diagnostic tests including glaucoma and cataract screening. Patients receiving AMD injections were also seen in the outpatients department.

We inspected this service using our comprehensive inspection methodology. We have reported our inspection findings against the two core services of Surgery and Outpatients. We carried out the announced part of the inspection on 16 and 17 October 2017, along with an unannounced visit to the hospital on 30 October 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 surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

We rated this hospital/service as requires improvement overall.

- We found that nursing staff were undertaking the extended role of dispensing medication for patients to take home without adequate training or competency.
- We observed nursing staff pre-operatively administering eye drops to patients before the surgeon had marked the eye to be operated on. This action did not comply with the World Health Organisation (WHO) surgical safety checklist supporting information, which recommends the site to be operated marked before any pre-medication administered.
- The resuscitation trolleys were not tamper proof at the time of our inspection. Staff had not consistently checked the resuscitation trolley in outpatients and diagnostics to ensure they were ready and safe to use.
- Permanent clinical staff compliance with mandatory training for basic life support was at 71%. This was against a target for all staff in therapeutic contact with the patient to have undertaken basic life support training.

Summary of findings

- There were some gaps in patients' records who had undergone laser treatment in outpatients and diagnostics. In one records out of 24 (4%) we reviewed the consent forms missing, and in three patient records out of 24, (12%) there was no record of the treatment undertaken on paper or electronically.
- There was some non- compliance with laser rules with 3B type of laser. For example, the key needed to operate the laser, was left in the laser when the outpatient consulting room was unattended. This was a concern as the room had a keypad entry, but could be entered by any member of staff who knew the key pad number, who may not be an authorised user of the laser.
- Not all staff were bare below the elbow in outpatients and diagnostics, and there was inconsistency with the use of personal protective equipment in outpatients and diagnostics.
- The service had a range of polices that were revised and updated, but the range did not cover all risks to patients. For example, there was no sepsis or antimicrobial policy.
- The hospital did not contribute to any national audits with regard to clinical outcomes. A local audit calendar was in place, but audits had not taken place as planned.
- There were gaps in the recruitment and ongoing monitoring of consultant practising privileges checks. This meant the registered manager did not have assurance of consultants' compliance with the provider's practising privileges policy.
- The service were not proactive in meeting individual needs patients may have. For example, there were no bariatric chairs, no adaptations for people living with a dementia.
- Mental Capacity Act training and deprivation of liberty safeguards training was at 29% for clinical staff.
- There was a risk register for the service. However, the provider had not developed an action plan to manage all identified risks. This included risks relating to waiting times in 2015, which remained outstanding.
- The hospital had only held one medical advisory committee meeting (MAC) in 12 months. The lack of MAC meetings meant the consultant ophthalmologists with their expert knowledge were not involved in monitoring governance processes at the hospital or as a committee supporting with decision making involving consultants.
- We reviewed the minutes of four of the hospital governance and risk meetings. Agenda items were inconsistent for example two meetings followed the suggested structure and two covered limited aspects of the agenda. This meant the opportunity for example to review the audit calendar, learn from any audits undertaken, review the risk register and discuss training issues/ compliance was not always taken.
- The service had not implemented the Workforce Race Equality Standards 2015 (WRES).

However, we also found areas of good practice:

- Staff followed their internal process for reporting incidents, and there was evidence of learning. All procedures and clinics went as planned.
- Staff working in the operating theatre demonstrated good compliance with the five steps to safer surgery (World Health Organisation –WHO) check list in the operating theatre.
- The hospital had recently put a standard operating procedure in place, and a risk assessment undertaken when cytotoxic medication used.
- The service followed national guidance and best practice by the Royal College of Ophthalmologists and National Institute for Health and Clinical Excellence (NICE) in relation to patient care pathways.
- Optegra as an organisation undertook clinical outcome audit activity. The hospital had an eye sciences department, whose role was to collate outcome data on refractive lens exchange (RLE), cataract surgery and laser surgery. The eye sciences team collected data for all Optegra hospitals each quarter and presented the data across the UK.

Summary of findings

- Patients were positive about their interactions with staff and the care they received within the department. They told us staff treated them with dignity and respect. Staff monitored patients' pain during procedures, and patients felt reassured and put at ease.
- The service was planned to meet the needs of patients. Referral to treatment times were not formally monitored, but patient feedback did not raise concerns about waiting times for treatment. Information leaflets were provided, and a monthly open meeting to support patients in making informed choices about their treatment.
- The service recognised people who required additional support to communicate and provided assistance in hearing and translation.
- The service did learn from concerns and complaints
- Staff were proud of the organisation as a place to work and spoke highly of the supportive culture. Staff we spoke with were happy with their working environment felt they all worked well together as a team. The leadership team were open and honest about where they felt the hospital needed to improve and responded proactively to the concerns we raised.

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 three requirement notices that affected the surgery and outpatients and diagnostic core services. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	Surgery and outpatients and diagnostic imaging were the only activities at the service. Surgery was the main activity of the hospital. Where our findings relate to both activities, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with outpatients and diagnostic imaging. We rated surgery overall as requires improvement.
Outpatients and diagnostic imaging	Requires improvement 	Surgery and outpatients and diagnostic imaging were the only activities at the service. Surgery was the main activity of the hospital. Where our findings relate to both activities, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with outpatients and diagnostic imaging. We rated outpatients and diagnostic imaging overall as requires improvement.

Summary of findings

Contents

Requires improvement

Optegra Solent

Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Optegra Solent Eye Hospital

Optegra Solent Eye Hospital is operated by Optegra UK Limited. The hospital/service opened in 2010. It is a private hospital in Hampshire. The hospital primarily serves the communities of Portsmouth and Southampton. It also accepts patient referrals from outside this area.

The hospital provides a comprehensive service to both NHS and self-referring patients covering the complete patient pathway, from ophthalmic consultations and diagnostics through to disease management or treatment including day surgery for adults only. These include refractive, ocular plastic, retinal, diagnostic and surgical services, and ophthalmic disease management. There were no beds at the hospital, as patients did not stay overnight.

Most NHS patients either self-referred or were referred by their GP or optometrist. Private patients self-referred to Optegra. Enquiries came via email, phone or website and were booked into Optegra patient administration software by the patient services centre.

Optegra Solent provides NHS eye services, mainly cataract surgery, for two NHS Clinical commissioning groups (CCGs).

The hospital is registered to provide the following regulated activities:

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

The hospital has had a registered manager in post since 2010. At the time of the inspection, there was a new manager appointed in January 2017 who was also the registered manager for Optegra Surrey. An application to be registered with the CQC as registered manager at Optegra Solent had recently been submitted.

The location previously had a planned inspection on 31 December 2013 and was found compliant against five essential standards of quality and safety inspected at that time.

Our inspection team

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

How we carried out this inspection

During the inspection, we visited consulting, treatment and diagnostic rooms, patient preparation and recovery areas and both operating theatres. We spoke with 23 members of staff including; registered nurses, health care technicians, reception staff, medical staff, operating department practitioners, and senior managers including the hospital director. We spoke with six patients and four relatives.

During our inspection, we reviewed 24 sets of patients' records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Summary of this inspection

Information about Optegra Solent Eye Hospital

Activity (1 July 2016 to 30 June 2017)

- For the period 1 July 2016 to 30 June 2017, there were a total of 1,995 surgical procedures recorded at the hospital
- The most common procedures were cataract procedures, of which there 973. Approximately 30% of these procedures were undertaken using intravenous sedation.
- During the same period, there were 260 refractive lens exchange procedures, 168 refractive laser procedures and 554 other procedures including laser procedures to address complications, age related macular degeneration (AMD) injections, retinol procedures, oculoplastic surgeries and glaucoma procedures.
- There were 6658 outpatient attendances in the same reporting period

We did not receive data on the volume of patient activity that was NHS funded, but the hospital director told us this was a significant proportion of the cataract surgery/ outpatient activity.

There were 14 ophthalmology consultants who worked at the hospital under practising privileges. The hospital employed one optometrist and nine registered nurses, four health care technicians (HCTs), one receptionist and eight patient's liaison staff. The hospital also used both bank and agency staff. The accountable officer for controlled drugs (CDs) was the registered manager.

From 1 July 2016 to July 2017 the hospital reported;

- The hospital reported one serious incident in the pre-inspection information, which when we reviewed would qualify as a never event, that occurred in August 2016. The incorrect power of intra ocular lens inserted into a patient's eye.
- There were no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA),Clostridium difficile (c.diff) or hospital acquired E-Coli.
- The hospital told us from 1 July 2016 to July 2017 there were 15 recorded complaints.

Services provided at the hospital under service level agreement:

- Clinical and non-clinical waste removal
- Pharmacy
- Interpreting services
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- Decontamination services

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:

- Nursing staff were undertaking the extended role of dispensing medication for patients to take home without adequate training or a competency.
- We observed nursing staff pre-operatively administering eye drops to patients before the surgeon had marked the eye to be operated on.
- A serious incident had been reported, which when we reviewed would qualify as a never event.
- The two resuscitation trolleys were not tamper proof, two new tamper proof trolleys had been ordered prior to our inspection. Staff had not consistently checked the resuscitation trolley in outpatients and diagnostics to ensure ready and fit for use.
- There was some non- compliance with laser rules with 3B type of laser. For example the key needed to operate the laser, was left in the laser when consulting room unattended. The room had a keypad entry, but could be entered by any member of staff who knew the keypad number, who may not be an authorised user of the laser.
- Not all staff followed infection control procedures such as bare below the elbow, and there was inconsistency with the use of personal protective equipment in outpatients and diagnostics.
- Clinical staff compliance with mandatory training for basic life support was at 71%. This was against a target for all staff in therapeutic contact with the patient to have undertaken basic life support training.
- There were some gaps in patients' records that had undergone laser treatment in outpatients and diagnostics. In one record out of twenty four we reviewed, the consent forms were missing, and in three patient records there was no record of the treatment undertaken on paper or electronically.
- Medicines fridge temperatures were not consistently checked in outpatients and diagnostics.
- The use of NHS FP10 prescriptions was not monitored at the time of our planned inspection.

However, we also found the following areas of good practice

Summary of this inspection

- Staff had reported incidents, and there was evidence of learning
- Scheduled theatre lists and outpatients clinics went as planned.
- Staff working in the operating theatre demonstrated good compliance with the World Health Organisation five steps to safer surgery checklist
- We observed good compliance with infection control in theatres and laminar flow usage
- The hospital had put a standard operating procedure in place, and a risk assessment undertaken when cytotoxic medication used.

Are services effective?

Good

We rated effective as good because:

- The service followed national guidance and best practice by the Royal College of Ophthalmologists and National Institute for Health and Clinical Excellence (NICE) in relation to patient care pathways.
- The hospital had an eye sciences department, whose role was to collate outcome data on refractive lens exchange (RLE), cataract surgery and laser surgery. The eye sciences team collected data for all Optegra hospitals each quarter and presented the data across the UK.
- Staff monitored patients' pain during procedures, and patients felt reassured and put at ease.
- The hospital followed guidance from the Royal College of Ophthalmologists regarding obtaining consent.

However

- The hospital did not contribute to any national audits with regard to clinical outcomes.
- A local audit calendar in place, but audits had not taken place as planned.
- There were gaps in the monitoring of consultant practising privileges checks.

Are services caring?

Good

We rated caring as good because:

- Patients were positive about their interactions with staff and the care they received within the department.They told us staff treated them with dignity and respect.

Summary of this inspection

- Patients were involved in decisions about their care and treatment, with options thoroughly explored and discussed
- Specialist support was available for patients with long term eye conditions, which could result in significant sight loss.

However

- Discussions during the discharge process were not held in private and could be overheard by other patients.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The service did not monitor how long patients waited for treatment, so did not know if patients wait time for treatment had increased.
- The service did have individual patient 'did not attend information', but was not currently reviewing DNA rates or acting on this information. This meant the referrer was not made aware by the service if a patient did not attend for treatment or an outpatient appointment.
- The service did not monitor waiting times for individual patients once they arrived for their appointment.
- The service were not proactive in meeting patients' individual needs patients. For example, there were no bariatric chairs, no adaptations for people living with a dementia.

However

- The service recognised people who required additional support to communicate and provided assistance in hearing and translation.
- The service did learn from concerns and complaints

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff demonstrated the corporately developed values, but were unable to name them and they were not displayed at the hospital.
- The risk register was not proactively managed. For example, a risk had been identified about patient waiting times in 2015. No audits had been undertaken, to support actions that may help reduce waiting times for patients.

Summary of this inspection

- The hospital had only held one medical advisory committee (MAC) meeting in 12 months. The lack of MAC meetings meant the consultants with their expert knowledge were not involved in monitoring governance at the hospital or as a committee supporting with decision making.
- We reviewed minutes of four of the hospital governance and risk meetings. Agenda items were inconsistent for example two meetings followed the suggested structure and two covered limited aspects of the agenda. This meant the opportunity for example to review the audit calendar, learn from any audits undertaken, review the risk register and discuss training issues/ compliance was not taken.
- The Workforce Race Equality Standards (WRES) 2015 had not been implemented at the hospital.

However

- We found the leadership team were open and honest about where they felt the hospital needed to improve and responded proactively to the concerns we raised.
- We found a cohesive and supportive leadership team, with well-established members of staff. Staff were complimentary about the support they received from their managers and commented that they were visible and approachable.
- Staff were proud of the organisation as a place to work and spoke highly of the supportive culture. Staff we spoke with were happy with their working environment felt they all worked well together as a team.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

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

We rated safe as **requires improvement.**

Incidents

- The hospital had an effective system for reporting and recording incidents. Staff we spoke with knew the process of reporting and investigating incidents. Staff understood and fulfilled their responsibilities to raise concerns and report incidents as well as near misses and were supported to do so.
- The hospital reported 33 incidents from July 2016 to June 2017. These included administration issues, medicines errors, communication breakdowns, equipment issues and information governance issues. Incidents were not identified as to whether they happened in surgery or outpatients and diagnostics.
- The hospital had not followed best practice guidance in ensuring they reviewed or recorded the level of harm for each incident. The incident log did not indicate the level of harm caused by these incidents. However, it did show what actions were taken and how learning was shared from these events.
- The registered manager told us the organisation was reviewing the system used to record incidents, and was going to discuss our feedback concerning the absence of a record of the level of harm with the head of governance. A record of the level of harm, would support staff in determining the management of the investigation of an incident, and if an incident triggered the duty of candour. A trial of a new system was taking place in two Optegra hospitals at the time of our inspection in October 2017.
- We saw examples of meeting minutes, which confirmed managers discussed learning from incidents and complaints with staff. Although we saw evidence that learning from incidents was shared with staff during staff meetings, meetings did not occur as frequently or as consistently as stated on the governance framework. For example the medical advisory committee had only met once from July 2016 to June 2017, instead of quarterly.
- Never events (notifiable incidents) 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. From July 2016 to June 2017, the hospital had reported no never events.
- From July 2016 to June 2017 there had been one serious incident recorded by the hospital. When we looked at the incident, the wrong power of intraocular lens was inserted into the patient's eye. When we reviewed this incident, the incident would qualify as a never event.. We reviewed the root cause analysis investigation for this event, which was reported to the Care Quality Commission (CQC) as a serious incident. We saw that the investigation was thorough and identified areas for improvement.

- Areas identified for improvement included the review and update of the local lens checking policy, the development of a bilateral lens surgery policy and sharing of findings and changes to practice locally and nationally.
- Managers told us that when things went wrong with care and treatment, patients were informed of the incident and were given information. This meant they were partially complying with the duty of candour requirement. Partially, as staff did not go on to explain to patients about any actions to improve processes to prevent the same thing happening again, when an investigation was completed. When we reviewed the root cause analysis for the never event that occurred, an action did not identify to share the learning with the patient, to prevent reoccurrence. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

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

- The hospital did not use a clinical quality dashboard to monitor safety or patient outcomes.

Cleanliness, infection control and hygiene

- The hospital maintained standards of cleanliness and hygiene and we observed all areas of the hospital to be clean and tidy.
- Clinical areas we visited were visibly clean, tidy, well organised and mostly clutter free. We observed staff washing their hands, using hand gel between patients and we observed all staff in surgery complying with the 'bare below elbows' policy.
- The hospital were not auditing staff compliance with hand hygiene as planned. The audit plan stated that hand hygiene audits should be carried out six monthly. The acting clinical services manager had undertaken an audit due to be completed in July 2017 three months later than planned on 13 October 2017. The hand hygiene audit had been undertaken in outpatients and not in surgery. From the information we had from the hospital, it was not clear when the last hand hygiene audit in surgery had been undertaken. However, handwashing by staff we observed in surgery was adequate for cleanliness.
- Personal protective equipment, such as gloves and hand-washing facilities were available. We observed surgical staff using personal protective equipment appropriately, and in line with: Health and Safety Executive (2013) Personal protective equipment (PPE): A brief guide. INDG174 (Rev2). London: HSE. We observed all staff using appropriate PPE in the theatre environment.
- Control and prevention of infection training was a training element, which staff should receive in the staff induction and mandatory training policy. Senior staff were unable to give us a record of when staff last completed infection prevention and control training. The infection control lead who provided the training had left a year previously. The acting clinical services manager told us an external provider had been requested to deliver training and undertake an audit. They were hoping this would take place either 14 or 17 November 2017.
- There were systems for the segregation and correct disposal of waste materials such as sharp items. Sharps containers for the safe disposal of used needles were available in the theatre. Staff had assembled and dated the sharps containers and they were not overfilled. This practice was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- The service had a contract with an external organisation for the removal and replacement of sharps boxes in order to make sure they were safely dealt with.
- Laser refractive surgery was performed in a minimal access intervention operating environment. A log was kept of temperature and humidity conditions demonstrating that equipment was being maintained consistently and safely.
- We saw cleaning rotas in the operating theatres which were completed daily and staff were clear about their roles and responsibilities regarding infection prevention and control.
- There were clear processes for the decontamination of reusable medical devices. There was a service level agreement with an external provider for the sterilisation of non-disposable equipment used within intraocular lens implant surgery.
- Staff followed best practice during surgery which included drapes around the surgical site and the use of sterile gowns and gloves. There was a designated staff member to ensure all swabs, needles and blades used,

were accounted for during and after the surgery and records were maintained. This further reduced the risk of surgical site infections and the risk of retained instruments and equipment post-surgery.

- Access to the operating theatre was correctly restricted. There was a separate clean and dirty utility area in the operating theatre to ensure that the risk of infection transmission was minimised. This was part of infection control process to keep patients safe by reducing the risk of surgical site infections.
- The hospital had not had any incidences of healthcare acquired infection in the last 12 months.

Environment and equipment

- We found that the clinical areas were well maintained, free from clutter and provided a suitable environment for dealing with patients.
- Emergency and resuscitation equipment was accessible in the theatre area. The resuscitation trolley in theatres had been checked daily, before theatre operating lists commenced. We checked a sample of consumables and these were in good order and in date.
- The resuscitation trolley was equipped with a defibrillator, oxygen and portable suction and we saw that emergency drugs were stored appropriately in tamper evident bags. It was noted however, that this trolley was not able to be sealed and so not all the items were 'tamper evident', in particular, it would not be evident if fluids had been tampered with. The registered manager told us that two new fully sealable and tamper evident trolleys were on order. When we went back for our unannounced inspection two new tamper proof resuscitation trolleys had arrived, and staff had planned to check them and then put them in to use.
- There were systems to ensure that equipment used during surgery were calibrated and the surgeon was also responsible to ensure that the necessary calibration checks were carried out.
- The service used single-use, sterile instruments as appropriate. The single use instruments we saw were within their expiry dates. The service had arrangements for the sterilisation of reusable instruments which were contracted out and monitored through a service level agreement with an external provider.
- Waste and clinical specimens were handled and disposed of in a way that kept people safe. This included safe sorting, storage, labelling and handling.
- Staff followed their process to ensure the anaesthetic machines and other equipment in theatre was in working order, which was essential to patient safety.
- A designated member of staff was responsible for overseeing and ensuring the maintenance, safety checks and servicing of equipment was undertaken effectively and that an accurate asset register was maintained for all equipment in the service. We checked a sample of items in the asset register and saw that these had up to date servicing records.
- Staff ensured the traceability for implants used in surgical procedures by retaining the bar codes with unique traceable reference numbers. Staff recorded this information in patients' medical records.
- Airflow was maintained in the theatre with greater than 15 changes of air per hour, which was in line with the Royal College of Ophthalmologists ophthalmic services guidance on theatres. The airflow system was tested and serviced annually and we saw evidence of its compliance with required standards.
- The laser room in the refractive suite was a large, visibly clean, clinical space with a clinical trolley. Staff carried out temperature and humidity check as Royal College of Ophthalmology professional standards. The facilities and procurement manager told us if the temperature and humidity changes not in an acceptable range, an alarm sounded and automated e mail generated to local managers on site and to the facilities team.
- We observed a procedure in the refractive suite. The class 4 laser was calibrated before use. (A high powered laser where non intended exposure can cause serious eye damage). A sign on the outside was illuminated to say that the laser in use. Staff had read, understood and signed the local rules for the class four lasers. A member of staff in the room assisted the consultant to ensure the laser operated safely, who had undertaken laser core of knowledge training. The laser protection supervisor was on duty in the hospital if required.
- The laser protection advisor (LPA) had reviewed laser safety last at the hospital in May 2016. Over all the LPA

concluded the hospital continued to maintain a high standard of laser safety throughout. The report was published 11 July 2016, and five actions that required implementation completed by 27 July 2016.

- For further findings on lasers used at the hospital, please see environment and equipment in the Safe section in the outpatients and diagnostics report.

Medicines

- The service had a medicines management and administration policy in place published in August 2017. The policy was reviewed to establish safe and best practice in the management and administration of medicines. The policy was readily accessible to staff via the organisation's electronic system.
- During our inspection, we found that nurses were dispensing prescribed medicines from the hospital supplies for patients to take home following surgery. Whilst the Nursing and Midwifery Council gives provision for this practice as being within nurses' scope of practice, the guidelines state that this must be in the course of the business of a hospital, and in accordance with a registered prescriber's written instructions and covered by a standard operating procedure (SOP). It also states that the patient has the legal right to expect that the dispensing will be carried out with the same reasonable skill and care that would be expected from a pharmacist.
- The medicines management and administration policy states:' Each Optegra hospital will have a standard operating procedure (SOP) for nurses dispensing medications from stock'. The SOP was put in place in response to other Optegra inspections. The policy also identified a medicines management training need. An external pharmacy company provided annual training which the representative from the external company told us dispensing medicines was included. When we spoke with three nurses they did not recall having medicines management training since their induction, and Optegra Solent do not include medicines management training as part of the mandatory training records.
- A nurse we spoke with did show us a power point presentation, stored in her professional portfolio folder, delivered by the external pharmacist on 27 July 2016. The presentation contained 63 slides, and one slide related to nurse dispensing. We were not assured that all nurses administering medicines have had additional medicines management training. An incident was reported in August 2016, where a patient post operatively had been given the correct eye drops but they had the wrong patient's name on. The hospital director told us that medicines management annual training was due to be delivered next at Solent Optegra 17 November 2017. Nursing staff had not completed the appropriate training for dispensing medicines
- We observed two patients who had eye drops installed into their eyes in preparation for surgery against a prescription, when the operation site had not been marked. This meant there was a risk that the eye drops could be installed into the wrong eye. The world health organisation (WHO) recommends marking of the operation site prior to any pre-medication being given.
- The hospital did have a theatre patient pathway standard operating procedure (SOP) in place dated August 2017, but this did not state the site to be operated on should be marked before any pre-medication given. The SOP stated 'ensure surgeon has marked site to be operated on' within a list of pre-operative actions.
- We checked a sample of medicines and found these to be in date. However, during monthly medicines audits carried out by an external company expired medications had been found. We reviewed audits completed from July to September 2017. The audits showed full compliance with management of controlled medicines, and on two of three audits expired medications identified. The August 2017 audit identified two expired medications, and the September audit did not identify how many medications had gone past their expiry date. When we reviewed minutes of meetings we could not see evidence of where these audit findings discussed, to try to ensure medications were always in date. The impact on patients was a potential delay if a prescription needed to be issued to obtain the medicine, or a wait by patients whilst medication delivered to Optegra.
- The hospital did not have an anti-microbiological policy in place. The head of governance confirmed a policy had been developed, and at the time of our inspection was being reviewed by a microbiologist.
- We saw accurate records were kept when medicines were administered and records included the patient's allergy status.

- The service had a service level agreement in place with a pharmacy; this also involved the provision of medicines management audits by this external contractor. We saw evidence that audits of stock, storage and medicines recording were undertaken at a minimum of three monthly intervals.
- Staff had recorded fridge temperatures in the theatre stock room through September 2017 and up until our inspection 16, 17 October 2017. The fridge temperature should be in the range 2 to 8 degrees, but maximum temperatures ranged between 7.9 and 12. The pharmacy representative thought this to be due to staff needing to put medications when they arrived into the fridge which took more than a few minutes. The pharmacy representative told us a new fridge with a different design on order, which it was hoped would address the issue.
- Registered nurses managed controlled drugs according to the policy. We checked the controlled drug register, and there was no missing information. Information included recording amount of medication given to patients, and any medication left in ampoules wasted as not required by patients.
- Optegra voluntarily suspended the use of Mitomycin whilst they reviewed its policies and processes in the safe handling and administration. The exception to this was if it was required for sight saving surgery. Mitomycin was used on a patient at the hospital the week prior to our inspection for sight saving surgery. Optegra had produced a standard operating procedure for the management and administration of Mitomycin C and this was adhered to. A Control of Substances Hazardous to Health (COSHH) assessment had been undertaken. We reviewed the notes of the patient who underwent the surgery, they demonstrated a thorough risk assessment had been undertaken. In addition, we saw evidence in the notes that the patient was fully informed of the risks and benefits of Mitomycin C and included information that it was not licensed for use in eye surgery.
- Mitomycin C main use is in cancer treatment but Mitomycin C may also be used for other purposes. Ophthalmology is not one of its licensed uses although it is used for clinical procedures including refractive eye surgery and glaucoma. This medication poses a risk to staff and subsequent patients, if not handled safely. Cytotoxic drugs, including Mitomycin C, are hazardous substances, as defined by the Control of Substances Hazardous to Health Regulations 2002 (COSHH). Under COSHH, employers must assess the risks from handling cytotoxic drugs for employees and anyone else affected by this type of work, and take suitable precautions to protect them.
- The cytotoxic spillage kit was manufactured in 2010. The registered manager said they had checked with the manufacturer and the kits can last up to eight years. The registered manager told us the hospital had recently submitted an order for replacement cytotoxic spillage kits.

Records

- We saw that the service had both hardcopy and some electronic patient records. For surgical patients this involved a physical file containing key records such as the WHO surgical safety checklist, medicine administration records, consent forms and pre-operative assessments
- We reviewed 24 patient records across surgery and outpatients and diagnostics. 21 of the records held details of the patient's full medical history in the service, including medicines records, diagnosis and treatment history. We also saw that the records contained observations immediately after surgery in the ward area where patients rested in comfortable chairs. Three records had some missing information. This included one patient having laser treatment in outpatients and diagnostics with no consent form in their notes. Also three patients having laser treatments in outpatients and diagnostics with no record of the procedure undertaken electronically or on paper.
- When we spoke with staff regarding the missing consent form they were not aware. The patient services team leader had undertaken a yearly consent audit on 10 October 2017 (due April 2017), which involved 10 patients medical records, and all the records had a consent form present. A registered nurse had completed a twice yearly documentation audit in September 2017, and all had consent forms. During the inspection we fed back our findings with regard to the missing consent form to the registered manager.
- The documentation audit in September 2017 had a compliance rate of 89%. The main gap was consultants

not printing their name or designation. There was no evidence of an action plan in response to the findings of the documentation audit. However, the registered nurse sent an e mail following the audit to all staff reminding them of their record keeping responsibilities.

- Patient risks were assessed and documented on pre-op assessment charts. The details were entered into the computer system, which took the nurse through standard sets of questions and assessments. The results were then printed and placed in the patient notes highlighting relevant aspects for that patient. For example, if a patient was diabetic, this was clearly identified on the list.
- Patients' records included information such as the patient's medical history, previous medicines, consultation notes, treatment plans and follow-up notes.
- The records included information specific to the treatment needed such as the recommended type and prescription of lens to be implanted during surgery based on various test readings.
- The serial number of the implanted lens was logged on the patient's records, as was any other equipment used during surgery. This meant there was an audit trail available that if there were any later issues with implants the patient could be tracked. Staff had fully completed the operating theatre register for procedures undertaken.
- The service retained all copies of the patient records and supplied patient information as needed to external professionals.
- The patient liaison staff we spoke with told us they made sure records were available for patients who were attending for surgery by checking the ward staff had these records before surgery took place. We confirmed this during the inspection and observed that records were made available as needed throughout the department. The record then went with the patient into surgery so a contemporaneous record of treatment could be maintained.

Safeguarding

- The service had a safeguarding policy in place and this was in date, had been reviewed and revised regularly and was accessible to staff.
- The service had a separate, on-site, safeguarding lead that was able to provide advice when necessary. At the time of our planned inspection the lead was unwell, and a deputy had been appointed to provide this support. The hospital provided information that the lead was due to undertake level 3 safeguarding training in February 2018, and the deputy was only trained to level 2. The registered manager told us there was a national corporate safeguarding lead that was also available to provide advice and oversight.
- Safeguarding vulnerable adults and children was included in the service mandatory training programme. Although the service did not treat children, they completed child protection training to ensure they were aware to recognise and respond to potential safeguarding issues concerning children associated to their patients.
- Despite training compliance gaps, staff we spoke with were familiar with their obligations regarding safeguarding and knew what they should do if they had concerns about a patient or their family. The hospital had also placed flow charts on staff notice boards to promote the recognition, reporting and raising of safeguarding alerts by staff.
- At the time of our inspection 16, 17 October 2017, we found that 77% of all permanent staff in the service had completed level 2 safeguarding adults and 86% level 1 children protection training. For bank staff only 20% had completed safeguarding level 2 training, but 70% had completed child protection training. The acting clinical services manager was monitoring compliance with mandatory training, and encouraging staff to complete their mandatory safeguarding training.
- We found that 72% of all permanent staff had completed 'Prevent' training, for bank staff the acting clinical services manager was confirming compliance with staff as the hospital did not have this information recorded. 'Prevent' training was undertaken by staff to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves.

Mandatory training

- The service had a staff induction and mandatory training policy. Staff members were required to undertake a range of general and role specific

mandatory training modules which were both online and in person. This was in line with the policy and the mandatory training schedule, which set out the frequency that each module was to be repeated.

- Subjects included basic life support, fire safety training, manual handling and equality and diversity.
- Overall mandatory training completion rates across the service for permanent staff were at 82% at the time of our inspection. For all permanent clinical staff compliance with basic life support was 71% and with intermediate life support 64%. For bank clinical staff the hospital had basic life training records for one out of the eight bank nurses. The organisation's resuscitation policy stated, "All staff who have therapeutic contact with patients will receive training in (as a minimum), adult basic life support (as currently detailed by the Resuscitation Council UK). This will be repeated every 12 months" and that managers must "Ensure that transient staff (Bank, Locum, agency etc.) have received training in adult basic life support in the last 12 months.
- The acting clinical services manager at our unannounced inspection explained that additional basic life support training and intermediate life support training had been arranged for staff to undertake in November 2017.
- At our planned inspection 16 and17 October 2017, eight modules for bank staff level of compliance were to be confirmed, as the hospital did not have this information recorded. This included the basic life support except for one member of bank staff where evidence of completion provided.
- For consultants in eight of the 10 personnel folders we reviewed, compliance with basic life support training was not evidenced, although for other mandatory training which is on line this had been completed. The two where basic life support training was evidenced were the two consultants who only undertook private work, and not any NHS work.
- The hospital target for compliance with mandatory training was 95%.

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

- The provider had exclusion criteria, which they applied to all referrals to ensure they risk assessed patients prior to accepting the referral and offering appropriate treatment. The hospital had criteria for refusing patients with certain health conditions and this was checked with the patient at their initial appointment. Patients completed a pre- appointment medical questionnaire ensuring the hospital had the relevant health information needed to contribute to the assessment and suitability for treatment. All necessary diagnostic tests were completed on the first appointment along with an assessment with the consultant. Only if deemed suitable were patients offered surgery.
- The service did not routinely weigh patients and so did not calculate body mass index (BMI), therefore did not use BMI as an exclusion criteria. As they did not weigh patients, they could not determine if maximum weight restriction for certain pieces of equipment were being observed During our unannounced inspection a member of staff told us they had been concerned about the weight of a patient who had attended for a procedure. The staff had checked the safe working load of the equipment the patient would use in the theatre and the safe working load was 250 kilograms.
- Consultant ophthalmologists carried out all ophthalmic surgery. A senior member of staff told us about 30% of patients requested IV sedation for their procedure. An anaesthetist was always present when IV sedation administered. It is a concern that the hospital did not weigh patients. The association of anaesthetists of Great Britain and Ireland (AAGBI) recognise that obese patients present a different set of challenges and require specific perioperative care when compared with non-obese patients. The AAGBI have produced guidelines on managing the obese surgical patient.
- A staff briefing was held prior to each surgical session. All staff involved in the surgery in the operating theatre attended. The meeting reviewed a brief summary of each patient undergoing surgery and highlighted any specific issues or concerns, such as any notable past medical history or comorbidities, any changes to the theatre list or specific equipment required for a particular case.
- The service had a 'World Health Organization (WHO) Surgical Safety Checklist Policy' in place. We observed the whole team to be engaged in using the checklist,

with all stages adhered to. A senior member of staff undertook a monthly notes audit to check compliance with the checklist, which from April to September 2017 had consistently been greater than 95%.

- There had been two incidences of unplanned transfer of care within the last 12 months. Both of these patients had a posterior capsular rupture following cataract surgery, which is a recognised complication. Their ophthalmologist followed up the two patients. One patient had further treatment at Optegra, and the other patient was treated at another provider.
- The hospital did not have a formal arrangement in place if a patient deteriorated. The hospital director told us the hospital relied on the fact that the NHS consultants would be able to admit patients if required to the trusts where they had a permanent contract.
- The hospital provided a 24-hour advice line which patients could telephone following their surgery. However, they were advised to seek emergency medical assistance for more serious matters following discharge.
- A company that supplied lenses for eyes sent a field notice in September 2017 regarding a brand of intraocular lens where incidences had been reported of the lens going cloudy. Senior staff had responded to the field notice and removed affected lens from the location, and reported the 23 patients they had treated following the lens clouding to the MHRA. The registered manager advised that MHRA had said no further action was needed at this time.
- A member of staff showed us protocols in the pre-operative area that consultants had in place to manage patients with diabetes safely.
- The acting clinical services manager had arranged some emergency scenarios, to support staff if there was an emergency. The first session was planned on 7 November led by the anaesthetist. The plan was then for monthly scenarios to be scheduled.
- Clinical staff we spoke with understood the importance of identifying sepsis and taking prompt action when required. Sepsis is a life threatening illness caused by the body's response to an infection. The hospital did not have a sepsis policy in place. The head of governance informed us that a sepsis policy was being developed.

Nursing and support staffing

- There were nine permanent registered nurses (equal to seven full time equivalents), four health care technicians (all full time) and one full time optometrist employed at the hospital. Most staff worked across outpatients and surgery when needed.
- Managers did not use a formalised staffing acuity tool to determine numbers of staff required. The acting clinical services manager assessed and anticipated the numbers of staff required based on the number and type of procedures and outpatient clinics that were being undertaken for that session. This information was then used to plan and schedule the appropriate numbers of nursing staff required. The acting clinical services manager and patient services manager met weekly to review staffing cover in surgery and outpatients.
- Staff told us there were enough staff on duty to maintain patient safety and this was confirmed by staff rotas we looked at.
- The hospital had its own 'bank' of nursing and technician staff that could be called upon when required. Data provided by the hospital prior to our inspection recorded that bank staff had covered 80 shifts from April to June 2017.
- The hospital had also used agency staff to cover 20 shifts and an agency operating department practitioner to cover 11 shifts from April to June 2017. The hospital used a regular small core of agency staff in order to assure some continuity in care.
- Sickness rates were recorded at hospital level only. The average rate of sickness from April 2017 to June 2017 was 0.6% for nurses and 1.6% for health care technicians. The hospital at October 2017 had two vacancies in theatres. A member of theatre staff told us the hospital was in the process of recruiting to the vacancies.

Medical staffing

- The service did not directly employ any medical staff but had 14 ophthalmologist consultants listed on their web site who worked across surgery and outpatients under the practising privileges scheme. Twelve of the

ophthalmologist consultants also worked in the NHS, and two only undertook private work. All of the consultants were on the general medical council (GMC) specialist register in ophthalmology.
- A consultant anaesthetist was always present when a patient had a procedure undertaken with intravenous sedation.
- Medical advice was always available for advice and consultation during opening hours. Input from the patient's own consultant was available by telephone if needed. Cover was provided by another consultant with the same sub speciality for any period of absence or leave by individual consultants.
- Although the service did not accept emergencies, a consultant or doctor was available during usual opening hours to review patients who might be experiencing difficulties post-operatively.
- The Optegra national medical director from whom advice could be sought on corporate medical matters, maintained medical oversight.
- Patients on discharge were given a telephone number that called be called 24 hours a day, if patients were experiencing post-operative complications.

Emergency awareness and training

- The hospital had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.
- The hospital had two back- up power supplies, that would last one hour if all electronic devices in use at the same time. The system was tested annually, as per the manufacturer's guidelines.
- Staff had received fire safety training as part of the mandatory training. A fire alarm test carried out weekly and a fire drill twice yearly. Fire exits and fire assembly points were clearly signposted and contained no unnecessary items.

Are surgery services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- The service followed national guidance and best practice by the Royal College of Ophthalmologists and National Institute for Health and Clinical Excellence (NICE) in relation to patient care pathways, cataract, medical retina, glaucoma, cornea and vitreoretinal procedures.
- The service had a range of local policies and procedures. These were reviewed and updated regularly and reflected current best practice and evidence based guidance. However, the medicines management and administration policy was revised in August 2017 following CQC inspections at other Optegra organisations, as the policy had not reflected best practice in relation to nurse dispensing. There were also an absence of policies required, for example sepsis and anti-microbiological policies.
- The hospital had an annual audit plan that included; World Health Organisation (WHO) safer surgery, lens checking protocol, hand hygiene, consent, clinical waste, environment, decontamination and documentation. However, staff had not always undertaken these audits when planned. Staff undertook the annual consent audit in October 2017 instead of April 2017, and monthly lens audits for February 2017 and June 2017 were missing. When we reviewed the minutes of meetings, staff had not discussed audit findings regularly to support improvements in practice.
- The hospital did not participate in any national audits and did not contribute to the National Ophthalmic Database Audit (NODA). The purpose of NODA is to collate anonymised data collected as a by-product of routine clinical care using electronic medical record (EMR) systems for the purposes of national audit, research and establishing meaningful measures for revalidation.

Pain relief

- Staff administered pain relief in the form of anaesthetic eye drops prior to surgery or procedures. Staff advised patients not to rub their eyes after the administration of eye drops. This was to prevent patients inadvertently scratching their eyes, through not being able to sense discomfort or pain in their eyes due to their eyes being numbed.
- Staff could seek advice and input from surgeons where patients complained of pain after surgery in the recovery area.

- Staff advised patients on pain relief during discharge discussions and advised on recovering at home. They were given a 24 hour helpline number but we told if the pain was severe they should go to their local accident and emergency department.
- Patients we spoke with stated that staff monitored and treated their pain levels appropriately. We observed a patient was administered an anaesthetic eye drop following laser surgery and clear advice was given on pain management. We observed staff asked patients about pain levels during and after procedures. Staff did not use a formal tool, but observed and asked patients if they were experiencing any pain or stinging.

Nutrition and hydration

- The hospital followed the Royal College of Anaesthetists guidance on fasting prior to surgery for patients receiving intravenous (into a vein) sedation. The guidance suggested patients could eat food up to six hours and drink clear fluids up to two hours before surgery. Staff advised patients of fasting times during their pre-assessment. We saw that staff asked patients to confirm the time they last ate and drank before surgery. This ensured the hospital complied with the Royal College of Anaesthetists guidelines. Patients who underwent intravenous sedation were offered refreshments after their procedure.
- Patients who were not having intravenous sedation were offered refreshments prior to and after their procedure.
- All patients were offered a choice of food and fluids post operatively and prior to discharge home.

Patient outcomes

- Optegra UK corporate leadership maintained an 'eye sciences' division, which amongst other activities managed the collection and reporting of clinical data from the hospital. Data collected included information on clinical complications, and visual and refractive visual acuity outcomes for laser, lens replacement and cataract patients.
- The eye science department clinical outcomes report for Optegra Solent reported complication rates and visual and refractive outcomes typically approximated or exceeded benchmark standards from July 2016 to March 2017. Data included refractive lens exchange, laser and cataract surgery outcomes. Further development work required to extend the collection of outcome data to other areas of practice, for example age related macular degeneration, vitreo-retinal surgery and glaucoma.
- Posterior capsule rupture (PCR) is a recognised complication of cataract surgery, occurring in around 1 in 50 patients (just less than 2%). Rates are higher in those with known risk factors, for example dense cataract. The hospital recorded that there had been two occurrences out of 973 procedures over the last 12 months prior to our inspection, which was a rate of 0.2 % and better than the national average.
- The hospital has had fifty-five incidences of unplanned re-treatment or treatment enhancement following refractive eye surgery in the last 12 months. 43 patients did not return within 28 days. 19 of these patients had laser enhancement following refractive lens exchange as part of their treatment pathway and 24 secondary lens implants. 12 patients had a redial of the lens following surgery. This is a surgical repositioning of an intraocular lens, which is undertaken for refractive reasons.
- We discussed this data with the eye sciences department as other Optegra organisations had less patients requiring enhancement of laser refractive surgery. The eye sciences department suggested the differences may be due to different healing rates for patients upon which the outcome depends. Also, that surgeons may have differing approaches to whether to offer an enhancement procedure and at what stage. Laser surgery volumes were also significantly different between the two hospitals, Optegra Solent had undertaken 328 laser vision correction treatments in the preceding in months, whilst other Optegra locations had undertaken under half this amount.
- There were 11 incidences of an unplanned return of a patient to theatre following refractive eye surgery in the last 12 months. Ten of these patients had a redial of their lens as described above. One patient had removal of a cloudy lens.
- Of 183 refractive eye treatments, 1.1% patients had experienced complications following refractive eye surgery in the last 12 months. This information, along with other outcome data, was used to benchmark the hospital's performance against other Optegra hospitals.
- Patient reported outcomes were also measured following discharge of patients. These were monitored

over time and benchmarked across hospitals and Optegra UK. For the period October 2016 to March 2017 for laser vision surgery and refractive lens exchange 97% to 99% of patients who were satisfied with the results. 422 patients who were treated at Optegra Solent responded to this electronic tablet based survey. For cataract surgery 98% of patients were satisfied with the results of their treatment. 646 patients who were treated at Optegra Solent responded to this electronic tablet based survey

- The hospital did not engage with the Private Healthcare Information Network (PHIN) so that data could be submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA). All providers of private healthcare in the UK are required by law to submit data to PHIN. The hospital director told us their eye science division were leading on this and they hoped to be involved later this year. The eye sciences deportment explained they were awaiting an update to their software, to facilitate submission of the required data.

Competent staff

- We reviewed the arrangements in place to determine if staff were competent to undertake their assigned roles. We reviewed staff training records, and saw there were competency documents for permanent qualified nursing staff : there was for health care technicians (HCT's). However, there was a lack of competency assessment for nurses dispensing medicines. We also noted that staff competencies once achieved, had not always been reassessed observed as detailed in staff personal records.
- The hospital had not ensured that staff responsible for the management and administration of medication were suitably trained and competent. We did not see evidence within staff files of qualified nurses to confirm they had undertaken comprehensive additional training to confirm competence in nurse dispensing.
- We saw evidence that a process operated for the granting of practising privileges. Appropriate checks such as disclosure and barring service (DBS), General Medical Council (GMC) and specialist registration, obtaining references, appraisal records and health screening must be carried out before practising privileges were granted.
- We reviewed 10 consultants practising privileges folders and in four of the records we checked there were no references and in four records only one reference. Also missing was up to date evidence of attendance at basic life support training in eight of the files.. Evidence of other mandatory training was up to date in the records we checked. Within the files we could see the hospital were actively chasing information missing in the consultant practising privileges records. The current level of checks did not meet with the Optegra practising privileges policy.
- The optometrist (undertakes primary vision care ranging from sight testing and correction to the diagnosis, treatment, and management of vision changes) had qualified as an independent prescriber in ophthalmology within level of competence in March 2017. The training had included a 12 day clinical placement at two local NHS trust trusts. The optometrist's role was governed by the general optical council. The optometrist was able to prescribe for general eye problems such as dry eyes, but not glaucoma treatment without consultant involvement.
- All new staff completed an induction programme, which included; health and safety, access to systems, mandatory training, human resources and policies and procedures. Staff had a six month probationary period. The hospital director told us that if poor performance was subsequently identified, this was managed by performance monitoring.
- The laser protection supervisor (LPS) and other staff working with the lasers attended core of knowledge laser safety training annually, unless there was a change in regulation. This was monitored, reviewed and audited via an on-line training tracker. This training was undertaken 20 October 2017, and had been due in March 2017. A senior member of staff told us the delay had been caused through difficulty in determining a day when no patient procedures and/ or clinics planned. The LPS told us the registered manager was planning to have dedicated training days at the hospital, to facilitate staff training compliance.
- The hospital was planning to have two laser protection supervisors in post rather than one. This would ensure there was always a LPS on duty when the lasers in use.
- Optegra UK's lead laser protection advisor (LPA) was provided by an external provider with whom Optegra had a service level agreement. The LPA reviewed competency, local rules and provided training. They undertook an annual audit and provided any action plans to the hospital if necessary.

- Consultants who operated the equipment and clinical team members who assisted with procedures, had signed to confirm that they have read and understood the local rules for each given laser. We saw an accurate record of the local rules were stored in the vicinity of the lasers. Consultant and clinical staff undertook laser core of knowledge training before operating or assisting with the use of lasers and this was monitored via an on-line training tracker. When any new lasers were introduced to the hospital consultants and staff supporting procedures undertook additional training before they were permitted to use it.
- Agency staff were booked through one single agency. An agency nurse we spoke with confirmed they had completed an induction, and undertook a similar role in another independent hospital.
- The learning needs of permanent staff were identified through a system of appraisals. At our planned inspection in October 2017, four of the permanent staff clinical appraisals were outstanding. These staff confirmed they had been arranged, but delayed due to a temporary change in senior staff cover.
- We spoke with a nurse who had recently revalidated with the nursing and midwifery council (NMC), and had felt supported by Optegra in submitting the information required for their three yearly revalidation. Revalidation is a continuous process that demonstrates nurses' ability to practise safely and effectively. The member of staff told us that the human resources department send e mails when nurses re-registration/ revalidation due and ensure process completed.
- All the consultant appraisals were up to date. However, only one appraisal stated when the consultants next five year revalidation due, and none stated who the responsible officer was for their revalidation. We checked the GMC register and all the consultants did have responsible officers. Optegra Solent were not following their own practising privileges policy, as they were not monitoring their own requirement to ensure medical practitioners are validated.
- The hospital supported the ophthalmology consultants with keeping up to date in their professional field. This included attending an annual ophthalmology conference.
- The consultants who performed refractive eye surgery were refractive practitioners who were all on the specialist ophthalmic register.
- A consultant we spoke with told us they did receive bench marked clinical outcome data. When we spoke with the eye sciences they monitored the data, and would ensure any concerns with outcomes investigated and followed up as required. The data was reported at the quarterly Optegra UK board.

Multidisciplinary working

- During our inspection, we observed good multidisciplinary teamwork between disciplines. All staff knew what their role was and how this fitted into the team. Staff told us that they worked together as a team and knew about each other's roles and responsibilities in the hospital.
- In theatres, we saw all disciplines of staff worked well together and everyone had a voice and their opinion heard. This was demonstrated at the WHO debriefing session we observed, the consultant surgeon ensured all team members were present.
- The hospital had effective external working relationships through service level agreements with external contractors to facilitate the effective running of the hospital. For example, this included the provision of pharmacy services, sterilisation of surgical instruments and cleaning.

Seven-day services (only if this is provided, if it is a day surgery service please remove this subheading)

- The hospital was normally open Monday from 7.30am to 7pm, Tuesday, Wednesday and Friday 7.30am to 6pm, Thursday 7.30am to 8pm and Saturday 7.30am to 1pm.
- The hospital provided a 24-hour helpline for advice to patients outside of normal working hours, this was covered by a qualified nurse. Consultants were available during normal working hours to review patients if staff felt it was required.

Access to information

- Patient records were both electronic and paper based. All staff had access to full details of a patient's past medical history, medicines, allergies, referral letters, consent information, clinic notes, pre-assessment notes, and consultants' operation notes.
- Paper records were kept on site for three months before being archived to an external physical storage facility, under a service level agreement. Documents could be recalled should they be needed after being archived.

- Staff had access to the information required to undertake their role. They had access to a range of policies, standard operating procedures and open source material via the computer system.
- The hospital sent patient correspondence to patients referring GP and referring optometrist as appropriate, with a copy to the GP, providing information pertinent to patients condition and treatment. The hospital only sent correspondence to the referring GP and referring optometrist if patients agreed.
- Following surgery, a copy of the discharge letter was given to patients on leaving the hospital. Copies were also sent to the patient's GP and or optometrist/optician if patients agreed to this information being with these health professionals. The letter recorded the procedure the patient had and details of any post-surgery medication they had been given to take home with them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff followed the corporate consent policy; the policy incorporated the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) legislation. The policy set out what the responsibilities of staff were when seeking and obtaining informed consent, including the type of consent (verbal or written) required for different procedures undertaken at the hospital.
- Staff we spoke with did understand the content of the Mental Capacity Act 2005 (MCA), and were aware there was a specially designed consent form used by consultants, if patients lacked capacity.
- Staff told us that they rarely treated patients who lacked capacity. However ,the capacity of a person to consent to a procedure was assessed by consultants and staff during consultation and pre-assessment. If a patients lacked capacity staff made a decision if the needs of the patient could be met at the hospital. If the patient's needs could not be met for example, if they required a general anaesthetic they were referred to an NHS trust.
- MCA and DoLS legislation training was part of the mandatory safeguarding vulnerable adults training. Data we received on site in October 2017 showed that compliance for permanent clinical staff with this face to face training was 29%, as that was the certificates the member of staff had visibility of at the time of our inspection. We did not receive any further data post inspection.
- The hospital had never had the need to seek a deprivation of liberty authorisation.
- Consultants were responsible for obtaining informed consent from patients, this was undertaken at consultation and confirmation of consent was undertaken on the day of the procedure. We reviewed eleven consent forms, all were fully completed were legible and did not contain any abbreviations. The hospital provided clearly written patient information indicating risks and benefits.
- The Royal College of Ophthalmology professional standards (April 2017) for refractive eye surgery state, "A minimum cooling off period of one week is recommended between the procedure recommendation and surgery". The five consent forms we reviewed complied with this standard.
- We also checked the consent forms of patients that had ocuplastic procedures (surgical treatment involving the eyes for medical and aesthetic reasons). For the five sets of patients notes we checked, the patients had all had at least a two week cooling off/ reflective period. This complied with Royal College of Surgery professional standards for cosmetic surgery 2016.
- Patients told us, and we could see in correspondence in patients' records, that they were given sufficient information in order to make an informed decision regarding treatment and informed consent.

Are surgery services caring?

Good

We rated caring as **good.**

Compassionate care

- Patients we spoke with were positive about the care they had received and told us nurses and doctors were kind and compassionate. For example, in theatres the consultant explained everything that was going to happen before at every stage of the procedure

Requires improvement

Surgery

- All staff we observed during pre-assessment appointments and during the checking in process were kind and respectful towards patients, taking their time to ensure they answered questions and concerns in full.
- A patient survey was sent out to patients in October 2016 capturing data from patients who used the hospital between 01 April and 30 June 2016.The survey captured data from seven Optegra hospitals ,Optegra Solent hospital had a response rate of 25%. Eighty-seven percent of respondents were positive about their experience at Optegra Solent.
- The hospital internally used the NHS Friends and Family test. The hospital did not submit NHS friends and Family data to the national data base. We saw data on a staff notice board for the period April to June 2017. 34 patients had completed NHS feedback forms. 32 indicated they would be extremely likely to recommend the hospital to friend and family, and 32 were indicated 'don't know'. Free text comments included, 'very reassuring staff, all queries and questions answered' and 'lovely people, very helpful and kind'.
- We observed staff, including reception staff and non-clinical staff were kind and caring towards patients who used the service.
- We spoke to 11 patients and their families during our visit and all patients we spoke to, spoke positively about their care; 'Excellent', 'Very, very, good' and a number of patients said the service was fantastic and there was nothing they would change.
- Out of the 21 comment cards we viewed from patients, 17 spoke positively with regards to all the care they had received. One patient wrote; 'I have had the best treatment anyone could have. All the staff are so great.' However, a comment card expressed a negative comment about the attitude of a member of staff.
- Pre and post op information was not discussed in private as discussions during the discharge process could be overheard by other patients. This is not best practice.

Understanding and involvement of patients and those close to them

- All patients we spoke with said they were aware of their surgical procedure and that the procedure had been explained to them thoroughly and clearly. For self-funded patients this included information about costs. Patients told us they had been given time to ask questions to ensure understanding.
- Patients were provided with written information prior to surgery to ensure they felt supported and prepared for surgical procedures.
- During the surgical procedures, we observed staff explained what was happening during each stage of the procedure and checked on the patient's welfare.
- Staff ensured that patients had the support they needed following a procedure and involved those close to patients to ensure they were supported when they returned home.
- We observed staff taking time to explain follow up care and instructions to patients and to answer their questions following surgery. This included how to correctly insert eye-drops at home, they also advised on take home medication details and after-care such as bathing and cleaning the eye. One of the 21 comments concerned a patient ringing the emergency number, and then having to call back three times before a member of staff called back. The patient did receive an apology, and was told the delay in a call back had happened due to staff sickness.
- Out of the 21 comment cards we viewed from patients, most were positive about being involved in their care, for example ' having laser surgery was one of the biggest decisions I have made and it was important to choose the right clinic and surgeon. I made the right choice and would recommend Optegra'. However, one comment described feeling rushed through tests.

Emotional support

- Each patient had a Patient Liaison who facilitated the pathway of the patient from referral to discharge and acted as the liaison between the consultant and patient should there be any queries or concerns that need to be addressed .
- The hospital provided clear information on pricing for different surgeries. Following surgery, refractive eye patients were given written information regarding follow up care. The hospital promoted the patients right to choice and were open and transparent regrading expectations and fees.

Requires improvement

Surgery

- We observed staff providing reassurance to patients, and patients in the comments cards to us, also described being 'put at their ease' by staff at the hospital.
- Staff understood the emotional impact that sight problems might have on patients. Staff told us that improving a patient's sight was what they were passionate about.

Are surgery services responsive?

Requires improvement

We rated responsive as **requires improvement.**

Service planning and delivery to meet the needs of local people

- The hospital opened in 2010. The hospital was designed to mirror the pathway of patients from consultation, with room for all relevant equipment for diagnostics through to disease management or treatment including facilities for day surgery for adults. The hospital had five consulting rooms, two operating theatres and one laser refractive theatre. The facilities were all situated on the ground floor.
- The hospital provided a modern, calm and comfortable environment. The hospital was easily accessible and well serviced by public transport and there was ample free parking within the immediate vicinity of the building.
- We saw that the facilities were spacious and fit for purpose. Staff and patients were positive about the environment.
- The hospital engaged with all key stakeholders for example local NHS commissioners in to understand what services were required. The hospital had a close working relationship with two NHS trusts. To support one of the trusts the hospital was planning to commission their second operating theatre for additional surgical activity. Activity was due to commence in January 2018, with Optegra Solent hosting additional operating lists in their second operating theatre five days a week.
- Non contracted NHS activity with a second trust had reduced. The registered manager told us this was due to financial arrangements for treating NHS patients treated at Optegra.
- The hospital provided pre-planned services only. This meant they had control regarding of the number of patients that they were able to accommodate. The hospital proactively forward planned surgical and clinic sessions of private, insured and NHS patients. They had flexibility to increase or decrease the number of surgical sessions required dependant on the patient need and at busy times.
- The hospital provided a 24 hour helpline for advice to patients outside of normal working hours. Consultants were available during normal working hours to review patients if necessary.

Access and flow

- The hospital did not provide an emergency eye surgery service. They provided for elective and pre-planned procedures only. The hospital referred any emergency cases to the appropriate emergency eye care services.
- We asked the manager how long patients waited for treatment. The manager advised us that they did not monitor wait times for treatment as this was not a contract requirement of the two clinical commissioning groups commissioning NHS work at the hospital, so we do not know what the wait times were for NHS patients. Although we asked we also did not get a clear picture of waiting times for private patients. From patient feedback, patients were happy that treatment time scales met their requirements. However, if a concern did develop with wait times, the manager may not be able to respond promptly, as wait times not monitored.
- We asked the manager about did not attend (DNA) rates for treatment, and although the service had records of patients who did not attend, the manager did not monitor DNA rates or have a protocol for when patients DNA. The manager told us that DNA rates for private patient cataracts, NHS patient cataracts and refractive lens exchange to be collected in the future. The manager was aware through data about individual patients, that private patients less likely to DNA, and for

self-pay patients the DNA rate was 9-10%.The concern was that due to DNA patients information not being acted on, the referrer would not know the patient had not attended for treatment.

- Patients were able to access the service via a range of means. Self-paying and insured patients were able to self-refer without a GP or optician's referral. Two local NHS clinical commissioning groups (CCGs) commissioned services from the hospital for appropriate NHS patients.
- NHS patients followed the NHS patient pathway which included an assessment of suitability and triage by a clinician. These patients required a GP or optometrist referral.
- All necessary diagnostic tests were completed on the first appointment along with an assessment with the consultant. If deemed suitable patients were offered surgery and added to the waiting list.
- Self-pay and insured patients were either referred by their GP, optometrist or they had self-referred. The details were logged on to the patient administration system and confirmation of the appointment sent out.
- All new appointments received a welcome call to confirm the patient's next appointment. The appointment letter included a map of the clinic with directions and parking information. A patient registration form and a medical questionnaire were also included.
- Access was timely for refractive surgery. There was no waiting list for refractive eye surgery. Three refractive eye surgery procedures had been cancelled for a non-clinical reason from July 2016 to June 2017. We reviewed incident records at the hospital, and two incidences had been recorded of a patient's surgery being cancelled due to the correct lens not being available. From the incident records we could see that one patient had been rebooked within 28 days. We asked the registered manager for further details about the cancellations, but further information not received.
- Patients completed a pre- appointment medical questionnaire ensuring the hospital had the relevant health information needed to contribute to the assessment and suitability for treatment.
- Telephone triage clinic appointments were in place to review patient's self-assessment information prior to surgery.
- The pre- assessment clinic was led by the optometrist and nurses. Patients were able to see the nurse or health care technician and have the appropriate health and diagnostic tests completed. For example baseline observations, blood pressure etc.
- Staff aimed for patient appointments to take between one to two hours. When we spoke with patients in the waiting area, two said they had been waiting for one and a half hours and the other half an hour. A member of staff had not spoken with the patients, to explain the delay. We spoke with the hospital director about monitoring of waiting times, and why this was not undertaken.
- The patient's surgical pathway was planned during pre-assessment. This ensured patients could consider whether dates for surgery and post-surgery appointments were appropriate and new dates could be considered according to patient preference to ensure flexibility.
- Patients arrived on the morning or afternoon of their planned surgery day. Patient arrival times were staggered, to reduce the time waiting for their surgical treatment. The consultant saw all patients before their surgery.
- Patients went into a pre-operative area that consisted of five large chairs with dividers. Staff explained they usually placed patients in every other space, so not directly next to each other. A staff member said that if patients wanted to have a private conversation, or staff needed to have a private conversation with a patient pre-operatively, it was possible to go into a private room. A staff member said this request was made by patients once or twice a month and was accommodated. Patients we spoke with did not express concern about this arrangement when we spoke with them, or in comments cards. From the pre-operative area, patients were escorted by staff into the anaesthetic room/operating theatre. When we looked at the detailed comments in the Trust pilot survey for patient reviews used by Optegra for Solent, patients had not fed any concerns back here either. From November 2016 to June 2017 there were 146 reviews.

Requires improvement

Surgery

- Following surgery patients went into a post-operative area which had four spaces and dividers. The extra space enabled patients to be brought through in the operating reclining chair if required. Patients' feedback did not indicate any concern with this similar arrangement to the pre-operative area.
- All patients were treated as a day case under a local anaesthetic or intravenous sedation.
- Patient treatment was scheduled in the same way regardless of being NHS or private patient and medically urgent patients, were treated as soon as possible as a priority.
- Nurses discharged patients following surgery after ensuring patients had recovered and were fit to go home. If they had any concerns, they could request a review by the surgeon involved.
- Patient told us they could book their follow up appointments during their pre assessment clinic visit. These ensured patients could identify times to suit them and to fit around their schedules.
- Patients were advised regarding post-operative care, how to use the medicines provided and given details of the 24-hour helpline should they have concerns following discharge.
- Staff arranged follow up appointments in the outpatients clinic for patient reviews, as required by treatment undertaken.

Meeting people's individual needs

- All surgical patients have a pre-operative assessment undertaken by a nurse to ensure individual medical needs could be met.
- There were no specific care pathways in place for patients with living dementia or learning disabilities. Staff told us how they rarely treated patients living with dementia or learning disability. Staff were able to give example of how they would adopt to accommodate their specific needs for example, ensuring patients were first on the theatre list and allowing relatives and carers to accompany them into theatre during their procedure.
- Staff did not have any specific training in caring for patients with a learning disability or dementia awareness, however, dementia training was included in the safeguarding vulnerable adult training.
- There were no adaptations in the environment for people living with dementia. For example, appropriate signage. However, there was staff available to guide patients where they needed to go throughout the hospital if required.
- Medical questionnaires were provided ahead of appointments for patients to indicate their personal and individual needs.
- Each patient had an allocated patient liaison member of staff who would act as the liaison between the consultant and patient should there be any queries or concerns that need to be addressed.
- The hospital provided individual lockers for patients' property. The lockers could be accessed both from the pre-operative area and the post- operative area.
- A hearing loop system was in place to help patients who have hearing aids.
- There was access to an interpreter and a choice of languages for standard literature. Patient information leaflets were also available in large font for patients with impaired vision.
- The optometrist ran an open meeting monthly on a Thursday evening when patients could attend to find about refractive surgery, and whether it might be the right thing for them. At the open evening patients were also given a tour of the hospital
- A wheelchair was available for patients who may not be as mobile but can access the clinic for their appointment.
- Patients had access to tea and coffee making facilities and water was available at all times in the reception area.

Learning from complaints and concerns

- The hospital had a system for handling complaints and concerns and followed the organisation's corporate complaints policy, which provided a structured process for staff to follow when dealing with complaints. We reviewed the policy and found it had recently been reviewed and was in line with recognised guidance and contractual obligations for independent hospitals in England.
- Staff told us that they tried to resolve complaints informally at the time to stop them escalating to formal complaints. Staff aimed to resolve issue there and then if the complainant felt the issue remained unresolved

then they were informed of the formal complaint process. The patient was given details of the complaints process and what to do should they wish to take their complaint further.

- A patient made a complaint to a member of staff during our inspection. The concern was that the patient was given a copy of the consent form of another patient in error to take home when they attended for their follow up appointment. On the day of surgery staff told us they had not been able to copy the consent form for the patient due to equipment failure. The patient suggested that it may help if the patients details were on the front of the form instead of the back. The registered nurse fed back the concerns to the acting clinical services manager who was going to follow up this informal complaint up with the registered manager. The patient was satisfied with this response. The patient also fed back this concern on a comments card to us.
- The service told us they had received 15 formal complaints from June 2017 to June 2017. One of these complaints had been upheld. When we spoke with the registered manager to ask about themes from the complaints, was ensuring patient decided on treatment having realistic expectations. A theme that had emerged was patient satisfaction with refractive lens exchange (RLE) surgery visual acuity outcomes. The registered manager advised that one of the reasons for the monthly open evenings was to ensure patients had every opportunity to gather information about RLE to make sure they were able to make a fully informed decision about treatment options.
- The complaints procedure was included within the patient guide, which we saw was available in the reception area. We saw leaflets around the hospital, which gave details on how to raise concerns, compliments or complaints. Patient feedback questionnaires were available in reception.
- A patient was advised that they may refer their complaint to the independent sector complaints Adjudication service (ISCAS) for an independent review. Details of how to do this were in the Optegra 'Feedback, comments and complaints' booklet.

Are surgery services well-led?

Requires improvement

We rated well-led as **requires improvement.**

Leadership / culture of service related to this core service

- The service was led by the hospital director who was applying to be the hospital's registered manager. The hospital director reported to the Optegra UK chief executive.
- The hospital director had been in post since January 2017 at Optegra Solent. The hospital director was also the hospital director and Care Quality Commission registered manager at Optegra Surrey hospital. The hospital director felt covering two hospitals was not enabling them to manage effectively, and plans were in place for there to be a registered manager employed for both sites.
- The hospital had a patient services manager and clinical services manager who were responsible for managing front-line staff and reported directly to the hospital director. The clinical service manager had been off sick for several weeks at time of our planned inspection in October 2017. The hospital director to ensure effective leadership, had appointed an acting clinical services manager in their place.
- There were clear lines of management responsibility and accountability within the service. Staff had a good awareness of who their line managers were which included their individual roles and responsibilities. Staff told us they all worked well together as a team. We saw teamwork was across the hospital with each staff member having a voice and an equal place within the team.
- Staff told us that local leadership was good and managers were visible, approachable, supportive and took an interest in their welfare. Managers we spoke with appeared knowledgeable about their patient's needs, as well as their staff needs. A consultant and the optometrist told us there was no pressure on them with to achieve a certain number of patients to accept treatment at the hospital.
- Staff were committed and passionate about making improvements for patients and felt they were able to

influence change. The optometrist had arranged an optometrists meeting just before our inspection, to enable ideas and challenges to be discussed, and support for the optometrists staff group. The optometrist also e-mailed other optometrist and the eye sciences department for advice and support when needed.

- There was an equality, inclusion and human rights policy in place. The policy described that every manager employed by Optegra was responsible for promoting equality inclusion and human rights in their sphere of management and for preventing undue discrimination in practice. The policy included clear aims and objectives.
- Due to the volume of NHS work at the hospital, they were required to meet the workforce race equality standards (WRES). The hospital director told us at present Optegra had not explored the impact of WRES on Optegra. The hospital director was planning to discuss the WRES at corporate level, to understand how the standards will be appropriately implemented in the independent sector as a whole.
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Vision and strategy for this core service

- The vision for the hospital was to provide an accessible, high-quality hospital based ophthalmology service to the local population and surrounding areas.
- The values displayed on the Optegra website were passion and commitment, integrity and trust, professionalism and expertise and personal connection and care. All the staff we spoke with demonstrated these values, but they were not displayed at the site and staff when we asked did not what the values were. Staff explained the values had been developed by the human resource department at corporate level, rather than by staff.
- Optegra Solent had a strategy in place for 2017/2018. The priorities were to continue to develop the highest possible care to their patients in a safe caring environment. Secondly, to continue to focus on improving the quality of the service with a commitment to serve excellence and improving together as a site. Thirdly, ongoing implementation and embedding the corporate review and standardisation of patient pathways.

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

- The hospital director was the location lead for governance and quality monitoring. The clinical services manager supported the hospital director.
- The governance structure in place was quarterly governance and risk meeting, hospital medical advisory committee meeting quarterly, hospital teams meetings (no frequency given), monthly clinical team meetings, monthly patient service team meetings, monthly patient service team meetings, weekly leadership team meetings and weekly operational meetings.
- The standing agenda for the hospital governance and risk committee meeting included patient satisfaction, human resource, health and safety, clinical governance, consultant governance, CQC key lines of enquiry and risk and finance and information technology.
- We reviewed minutes of four of the hospital governance and risk meetings. Agenda items were inconsistent for example two meetings followed the suggested structure and two covered limited aspects of the agenda. On the agenda 7 June 2017, items discussed were a review of the previous meeting minutes, action tracker, mock CQC inspection, risk register, complaints register and incidents. On the 30 June 2017 the only item listed was the risk register, and two brief bullet points about the need to add risks to the risk register and what should be added. The minutes from the meeting 17 August 2017 did not include any discussion relating to the risk register, audit or training. This meant the opportunity for example to review the audit calendar, learn from any audits undertaken, review the risk register and discuss training issues/ compliance was not taken.
- The medical advisory committee meetings had not been well supported. Since June 2016, there had been one medical advisory committee meeting held, and that was held on 20 July 2017. The MAC supports the hospital in monitoring safe, effective and responsive care by reviewing and providing feedback on, the clinical and quality governance reporting. This included reporting on and learning from incidents, never events, candour, implementation of new policies, complaints, outcomes, patient satisfaction, and reviewing and granting consultant practising privileges. The lack of MAC

meetings meant the consultants with their expert knowledge were not involved in monitoring governance at the hospital or as a committee supporting with decision making involving consultants.

- The registered manager told us that at the meeting held in July 2017, one consultant had been present and that was the chair of the MAC committee. The registered manager told us the practising privileges policy was being reviewed, and part of the role and responsibilities of the consultants with practising privileges would be to attend an agreed amount of MAC meeting a year. The registered manager did not provide us with a date of when the new practising privileges policy would be launched. The date for the next MAC meeting was also not on the meeting minutes of the meeting held 20 July 2017. A consultant we spoke with, said one of the issues was the scheduling of the MAC meetings, to support consultants with practising privileges being available to attend the MAC meetings.
- Clinical team meetings and patient liaison team meetings were well attended and from the minutes seemed to be occurring monthly. These provided a forum for staff to discuss issues such as incidents, operational challenges and patient satisfaction. A member of staff told us that weekly leadership team meetings had not been happening due to staffing challenges, but it was hoped to be able to restart the weekly leadership meetings soon, when recruitment had taken place.
- The hospital had a risk register in place, with 10 active risks. Six dated back to 2015, and four risks added in June 2017on three different dates. One of the risks active from 2015, was concerns about waiting times in the patient satisfaction survey. The registered manager said they were not monitoring this information as their IT systems did not facilitate the capture of this data. The hospital had also not undertaken any audits of waiting times. This lack of action and monitoring of progress can be understood, when reviewing the meetings of the hospital governance and risk meeting. The registered manager in June 2017 had created a risk regarding the lack of attendance by consultants at the MAC meetings.

Public and staff engagement (local and service level if this is the main core service)

- The service had a website where full information could be obtained about the treatments available for patients. It was very comprehensive including information about costs and finance. The Optegra website advertised a free no obligation quote, to assess private patients' suitability for refractive eye surgery.
- The hospital did not have a patient forum, forums are usually open to patients and relatives to discuss any issues they may have about the hospital.
- To support staff morale, Optegra had a staff recognition scheme whereby staff could nominate individuals and teams. Morale was good at the hospital, all staff we spoke really enjoyed the comradeship they felt working at the hospital. Staff were also supported to develop their knowledge and skill. Health care technicians we spoke with and the optometrist were particular examples.
- Optegra, which included Optegra Solent, had achieved number one in category on a public website which publishes reviews from customers for online businesses. They had been voted by the public as 'Best in category' for eye treatment and rated 9.6 out of 10 based on 1,479 reviews. We reviewed the comments made regarding Optegra Solent that included ' liberating' and 'fantastic results'.
- An annual colleague engagement survey was conducted with the results shared openly with colleagues and action plans developed.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- The hospital director wanted to increase the number of vision correction consultants, as currently there was only one. This was to support increases in demand for vision correction procedures.

Requires improvement

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as **requires improvement.**

Incidents

- All staff spoken with in the Outpatient Department (OPD) told us they were supported to raise any potential risks or concerns. They were confident that they were made aware of how to raise incidents. Staff also told us they were informed of learning as a result of incident investigations that assisted in improving the services performance.
- Never events (notifiable incidents) 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. From June 2016 to June 2017 the outpatient and diagnostic department had reported no never events.
- For our detailed findings on incidents please see the Safe section in the surgery report

Cleanliness, infection control and hygiene

- The outpatient consulting rooms and waiting areas were visibly clean. Staff monitored the cleanliness of general outpatient areas. Cleaning staff completed daily general cleaning checklists to confirm which areas had been cleaned. We observed staff washing their hands adequately, and using hand gel between patients
- The audit plan stated the hospital should carry out hand hygiene audits six monthly. The acting clinical services manager had undertaken an audit due to be completed in July 2017 on 13 October 2017. This had been undertaken in outpatients. The audit did not give information on the number of staff audited. However, it identified several areas for improvement including that hand hygiene was not part of the induction process and that staff had been observed wearing jewellery. It was unclear what plans were in place to address these issues as had action plan following the audit had not been completed.
- Personal protective equipment, such as gloves and hand-washing facilities were available. We observed most staff using personal protective equipment appropriately, and in line with: Health and Safety Executive (2013) Personal protective equipment (PPE): A brief guide. INDG174 (Rev2). London: HSE. We observed a member of staff was not using all PPE available, and this was fed back to the registered manager.
- There were systems in place for the segregation and correct disposal of waste materials such as sharp items. Sharps containers for the safe disposal of used needles, that were not re-sheathed prior to disposal by staff, were available in consulting rooms and laser treatment rooms. These were dated and were not overfilled. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- For our detailed findings on cleanliness, infection control and hygiene please see the Safe section in the surgery report

Environment and equipment

- Records indicated that equipment on the resuscitation trolley in outpatients was not always checked when the hospital was open. In September 2017 there was no signature to indicate the trolley had been checked from

Monday 4 to Thursday 6 September 2017, Friday 8 September 2017 or Wednesday 13 September 2017. Since 13 September 2017, the trolley had been checked consistently when the hospital was open.

- We saw that emergency drugs were stored appropriately in tamper evident bags. It was noted however, that this trolley was not able to be sealed and so not all the items were 'tamper evident', in particular, it would not be evident if fluids had been tampered with. The registered manager told us that two new fully sealable and tamper evident trolley were on order. When we went back for our unannounced inspection two new tamper proof resuscitation trolleys had arrived, and staff were planned to check them and then put them in to use.
- Within outpatients there was a class 3B laser (medium powered and non- intended exposure can cause serious eye damage) in a treatment room and a class 4 laser (high powered and exposure can cause serious eye damage) in a treatment room.
- The treatment room with the class 3B laser, had an illuminated sign to indicate when the laser in use. When we inspected the interlock was not working, which locked the door and automatically turned the sign on. The consultants had to lock the door and turn the sign on manually, as they chose to work without an assistant during this patient treatment. The fault had been reported to facilities in April 2017 and May 2017, and had been on the risk register since June 2017. This risk was put on the risk register following an incident when a nurse walked into the room when a laser procedure was being performed. When we discussed the interlock not working during our inspection, the hospital director told us a quote was to be obtained by facilities to have the interlock repaired.
- We observed on our planned inspection a key needed to operate this class 3B laser had been left in the laser which does not comply with the rules of using the laser which had been signed by the authorised users of the laser. When we revisited the room on our unannounced inspection the key was not in the laser. The laser protection supervisor had discussed our observation with the registered manager. The LPS with the registered manager had now decided a key press would be fitted in the room, to store the key to this class 3B laser.
- A class 4 laser was in use in a treatment room within outpatients. This was used by one consultant, and we were told approximately every six weeks, and had been used for approximately a year for patient treatments. The sign to indicate the laser was in use was a temporary one that staff had to remember to blue tack on the door before the laser used. When we discussed this risk with the hospital director, the LPS and registered manager decided it would be possible and may be safer if the laser was used in the room with permanent laser signage.
- The LPS was planning to discuss these actions when the LPA came to undertake their annual review of laser safety at the hospital 20 October 2017.
- All equipment we looked at was stored appropriately.
- There was a planned preventative maintenance schedule with appropriate checks in place.
- An external maintenance team were responsible for annual safety testing. The equipment we checked had an up to date safety test and appeared in good condition.
- For our detailed findings on environment and equipment please see the Safe section in the surgery report

Medicines

- Medicines were securely stored in locked cupboards. This meant the department followed the appropriate guidance on the safe handling of medication.
- Lockable fridges were in place, with daily temperature checks. However, staff had not recorded fridge temperatures in the diagnostic treatment room from Monday 4 to Wednesday 6 September 2017 or on Friday 8 September 2017. Since the 8 September 2017, fridge temperatures have been recorded. This meant there was a risk that medicines may not be stored within the manufacturers recommended temperature range. On one occasion, staff recorded a fridge temperature that was out of range, which was reported.
- The hospital held a regular NHS outpatient clinic. In the NHS outpatient clinic NHS prescription pads called FP10 were in use. The hospital did not keep an audit trail of prescriptions used by consultants as per the current medicines management guidelines. We raised this as a

concern during our inspection . At our unannounced inspection, a senior staff member had put a system in place enabling each NHS prescription issued to be accounted for.

- The optometrist (undertakes primary vision care ranging from sight testing and correction to the diagnosis, treatment, and management of vision changes) had qualified as an independent prescriber in ophthalmology within level of competence in March 2017. The training had included a 12 day clinical placement at two local NHS trust trusts. The role was governed by the general optical council. The optometrist was able to prescribe for general eye problems such as dry eyes, but not glaucoma treatment without consultant involvement.
- In outpatients an emergency box to treat any patients presenting with a serious eye infection was in place. We checked, and all medications within this box were in date. The infection control policy contained a current protocol on how to manage a patient presenting with a serious eye infection.
- Staff in outpatients told us they had recently stopped dispensing tablets to take out for patients. The consultants now gave patients a private prescription.
- Staff managed cytotoxic medication in the outpatient safely. This included the medication being received from at the hospital in prefilled syringes, and the use of dedicated sharps bins for the safe disposal of cytotoxic sharps.
- For our detailed findings on medicines please see the Safe section in the surgery report.

Records

- The consultants who had undertaken procedures in the consulting room with the class 3B laser recorded the energy from the laser but not always the pulses. For example on 2 October for one patient and for three patients on 4 October only the energy was recorded. This information is useful as part of the review of clinical outcomes. The laser protection supervisor (LPS) was planning to discuss this record keeping gap with the LPA. The laser protection advisor (LPA) was due to visit the site Friday 20 October 2017 to provide training and support. When we went back on our unannounced inspection 30 October 2017, the LPS had changed the format for recording. The LPS had now set format out that energy and pulses to be recorded in one box, instead of two separate boxes.
- Patient care records generated in outpatients such as treatment information were kept within the department when needed for treatment and were easily accessible. Once finished with these were then move to an external storage provider where they were kept until needed.
- Paper records used in the outpatient department were stored securely. Electronic records were only accessible to authorised people. Information was manually inputted from the diagnostic testing equipment into the electronic records as there was not a direct link. Computers and computer systems used by hospital staff were password protected. Staff we observed locked their computer screens to prevent unauthorised access when they were not in use.
- Patient records were usually available when needed in the outpatient clinics. The reception staff managed the transfer of records in and out of the clinics. There was a tracking system in place to ensure that the location of individual records could be identified.
- Electronic records contained copies of information sent to private patients regarding the costs of their treatment in order to provide the patient with relevant information before they agreed to the treatment.

Safeguarding

- The hospital did not offer appointments to children in outpatient clinics. All patients were over the age of 18. The hospital recognised staff may come into contact with children, if they accompanied their relatives for an outpatient appointment.
- All permanent staff had access to level 2 safeguarding adults and child protection training.
- Staff understood their responsibilities and were aware of local safeguarding policies and procedures. The clinical services manager was the allocated local safeguarding lead.
- We saw that there were local and national safeguarding policies and procedures in place, which staff in the service knew how to access. The hospital had also placed flow charts on staff notice boards accessible to staff working in outpatients, to promote the recognition, reporting and raising of safeguarding alerts by staff.

Requires improvement

Outpatients and diagnostic imaging

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

Mandatory training

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

Nursing staffing

- There were nine permanent registered nurses (equal to 7 full time equivalents), four health care technicians (all full time) and one full time optometrist employed at the hospital. Most staff worked across outpatients and surgery when needed. The hospital used regular bank nursing and optometrist staff to cover shifts in outpatients.
- The hospital had not cancelled any outpatient clinics due to a shortage of staff.
- The team lead had become aware of extra tests being requested by consultants'. The team lead had recently started an audit of tests requested to ensure staffing could continue to be planned effectively.
- For our detailed findings on nurse staffing please see the Safe section in the surgery report

Medical staffing

- The service did not directly employ any medical staff but had 14 ophthalmologist consultants listed on their web site who worked across surgery and outpatients under the practising privileges scheme. 12 of the ophthalmologist consultants also worked in the NHS, and two only undertook private work. All of the consultants were on the general medical council (GMC) specialist register in ophthalmology.
- For our detailed findings on medical staffing please see the Safe section in the surgery report

Emergency awareness and training

- For our detailed findings on emergency awareness and training for this core service, please see the Safe section in the Surgery report.

Are outpatients and diagnostic imaging services effective?

We do not currently rate the effectiveness of outpatient's services.

Evidence-based care and treatment

- Patients' needs were assessed and care was delivered in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. For example, protocols were followed with regard to national guidance for treatment of glaucoma and age related macular degeneration.
- Staff were kept up to date with changes in practice. They had access to guidelines from NICE and used this information to deliver care and treatment, which met patient's needs. For example, staff received National Patient Safety Alerts and alerts from the Medicines and Healthcare products Regulatory Authority. This meant they had accurate and up to date information confirming that best practice guidance was used to improve care and treatment and patient's outcomes.
- The hospital did not participate in any national clinical audits relevant to the outpatients department.
- Patients were screened about their suitability for treatment by the optometrist before their appointment with the consultant, at the pre assessment appointments. However, the assessment did not include a body mass index measure, which could put patients with a high body mass index at risk if operated on and they received intravenous sedation prior to a procedure being undertaken.

Pain relief

- For our detailed findings on pain relief for this core service, please see the Effective section in the surgery report.

Nutrition and hydration

- Due to the nature of the service, the OPD did not provide food and drink specifically. We observed that there was a hot drink machine and biscuits available in the reception area that patients were observed to freely access. The biscuits included some that were gluten free. Patient's relatives were also encouraged to access this provision.

Patient outcomes

- For our detailed findings on patient outcomes for this core service, please see the Effective section in the surgery report.

Requires improvement

Outpatients and diagnostic imaging

Competent staff

- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. There was an induction programme for all newly appointed staff.
- For our detailed findings on competent staff for this core service, please see the Effective section in the surgery report.

Multidisciplinary working

- Patients referred for assessment and treatment of cataracts were seen by a consultant, optometrist a nurse or health care technician, and also had any necessary tests, such as diagnostic tests. The pre-assessment visit ensured that all essential tests were completed on the same day in one appointment. Staff told us that optometrist and ophthalmic consultants worked well together.
- Discharge letters were sent to GPs following outpatient appointments that detailed the treatment given and advised of any further treatment that was planned.
- Patients seen for management of conditions such as glaucoma and age related macular degeneration benefit from close working of the patient liaison team, consultants, optometrist, nursing staff and healthcare technicians.
- For our detailed findings on multidisciplinary working for this core service, please see the Effective section in the surgery report.

Access to information

- The patient liaison team printed a list of patients attending outpatients every day, this was initially reviewed by the outpatient nurse in charge or health care technician, to ensure staff could effectively prepare for a clinic.
- Clinic staff had access to a folder of patient pathways, and for each consultant there was a list of appointment type information, for example, cataract, retinal, retinal follow up.
- For our detailed findings on access to information for this core service, please see the Effective section in the surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed eleven records with regard to consent and consultants were following the hospital policy on consent to ensure that patient consent was gained for each procedure, and cooling/ reflection periods observed. This complied with the Royal College of Ophthalmology professional standards.
- We saw there were dedicated consent forms for treatments undertaken in the outpatients, for example cytotoxic injections for age related macular degeneration and glaucoma. The consent forms detailed the aims of treatment, risks and benefits.
- For our detailed findings on consent, mental capacity act and deprivation of liberty safeguards for this core service, please see the Effective section in the surgery report.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

- We observed staff interaction with patients these were positive in nature. Patients spoken with told us that, “They were all so caring and ‘excellent treatment.’
- We saw positive interaction from staff in clinic rooms and waiting areas, consistently throughout the inspection. Staff were kind towards patients, joking and smiling with them and putting their mind at ease.
- Patients spoken with told us that that they were treated with dignity and respect by all staff members. All patients we spoke with said they found the staff polite, friendly and approachable.
- We saw in outpatients consideration was given to preserving patients’ dignity, and respecting patient confidentiality. For example, patients were seen individually in a consultation room, discussions regarding care pathways were addressed in private, and where patients did not wish their GP to be informed this was respected.

Requires improvement

Outpatients and diagnostic imaging

- Staff told us and we observed that patients' relatives were supported to attend appointments and this occurred several times whilst we observed staff support to patients. Staff told us relatives were welcomed and supported to attend with their family member.
- A notice by the tea and coffee making facilities in the outpatient area advised patients if they would like a chaperone, to ask staff so a chaperone could be provided. If a patient did not make themselves a cup of tea of coffee, they would not be aware this support was available unless they asked a member of staff.
- For our detailed findings on compassionate care for this core service please see the Caring section in the Surgery report.

Understanding and involvement of patients and those close to them

- Staff and consultants introduce themselves when patients were called in for their appointment slot.
- Patients told us they felt involved in decision making about the care and treatment. We observed the optometrist assess a patient for refractive leans exchange and following introductions the first question asked ' what outcome would you like to achieve? There then followed a very detailed discussed about options with full explanations, and impact of each. Information included details about costs.They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choices of treatment available to them.
- Services were planned to meet the needs of patients. Patients had a choice of consultant ensuring continuity of care. Appointments were flexible and staff booked assessments on the same day to reduce travel for patients.

Emotional support

- We spoke with patients and their relatives who told us they felt supported and staff members were warm and welcoming. Records showed and was confirmed by patients that they were given verbal information and support regarding their treatment.
- Patients told us that the staff put them at ease on arrival.
- Records showed that some of the patients had a diagnosis of long term conditions, such as glaucoma where the optic nerve is damaged by the pressure of the fluid inside the eye. Patients with glaucoma can develop significant sight loss. A consultant specialising in glaucoma diagnosis and management was able to treat patients and provide support as needed to patients.
- Throughout our visit we observed staff giving reassurance to patients with additional support given when it was required, especially if patients were apprehensive.

Are outpatients and diagnostic imaging services responsive?

Requires improvement

We rated responsive as **requires improvement.**

Service planning and delivery to meet the needs of local people

- Patients we spoke with said the waiting area in reception was comfortable. Hot and cold water and tea and coffee were available in the reception area. People could help themselves when they wanted.
- Information leaflets were available regarding eye treatments available at the hospital.
- Patients and staff confirmed appointments were planned and booked in advance. These sessions were dependent on surgeon availability.
- The service used the appointment systems to plan clinic sessions to identify number of patients who would be attending each day. They used this information to decrease or increase the number of clinical appointments required to meet the needs of patients and to maintain flexibility of staff.
- The hospital identified patients who may be in need of extra support when they completed their initial assessment information. For example: patients with communication difficulties**.**
- The hospital had a dedicated member of staff whose role was to discuss with patients the finance details. They told us they discussed costs for each procedure. Patients were given full written details of the charges for their treatment and plan for treatment.

Requires improvement

Outpatients and diagnostic imaging

- Patient toilets were available throughout the clinic areas and immediately next to some waiting areas. This included two disabled toilets, one in main reception area, and one in the consulting room area.
- The site had 65 free patient car parking spaces, including six disabled places.
- Patients were seen in private rooms in outpatients. Each consulting room had an alarm staff could ring if help required urgently.
- The optometrist from January 2018 had re-organised their clinics, to ensure their time used most effectively in meeting patients' needs.
- For our detailed findings on service planning and delivery to meet the needs of local people, please see the Responsive section in the surgery report

Access and flow

- Patients accessed the outpatient's service via a referral from their GP, optometrist or self- referred privately.
- It was unclear how long NHS patients waited for treatment..Hospital appointments were dependent on the clinician's availability. The two clinical commissioning groups that commissioned work from the hospital did not in their contracts require the hospital to monitor waiting times for treatment. Private patients we spoke with were happy with the time they had waited for initial appointments and then treatment, and no concerns were raised in the 21 comments cards we received about waits for appointments or treatment. However, the manager did not have a system in place to alert them to monitor waiting times, so would not be aware if they had increased.
- Waiting times for appointments were variable. Most patients were seen within 15 minutes, however two patients we spoke with had waited longer. One patient told us they had waited nearly an hour and half to be called, the other 30 minutes. Both patients told us a member of staff had not approached them to explain why the clinic was delayed. Total visit times in outpatients were not monitored by the hospital and an estimated total visit time was not displayed at the reception desk of each clinic.
- There were no audits to monitor the time patients spent within the hospital. This meant they were not able to give patients an idea of how long appointments were likely to take and enable them to plan for their visit and arrange transportation.
- We asked the manager about did not attend (DNA) rates for outpatient appointments, and although the service had records of patients who did not attend, the manager did not monitor DNA rates or have a protocol for when patients DNA. The manager told us that DNA rates for private patient cataracts, NHS patient cataracts and refractive lens exchange to be collected in the future. The manager was aware through data about individual patients, that private patients less likely to DNA, and for self-pay patients the DNA rate was 9-10%.The concern was that due to DNA patients not being monitored, the referrer would not know the patient had not attended for their outpatient appointment.
- There were systems in place to triage patients on the waiting list. Referrals were triaged by nursing staff.
- All necessary diagnostic tests were completed on the first appointment along with an assessment with the consultant. If deemed suitable patients were offered surgery and added to the waiting list.
- Patients completed a pre- appointment medical questionnaire ensuring the hospital had the relevant health information needed to contribute to the assessment and suitability for treatment.
- On arrival, patients reported to the main reception where they would then wait until collected and taken to their consultation room. There was sufficient space and flexibility for the number of patients being treated at the time of inspection.
- For our detailed findings on access and flow please see the Responsive section in the surgery report

Meeting people's individual needs

- The environment was observed to be pleasant but we saw that there were limited adaptations to people living with dementia or a learning disability, such as appropriate signage. Staff did undertake dementia awareness training. Staff we spoke with were not aware of a specific dementia or learning disability strategy. Staff did encourage relatives to be with patients, if this was wanted by the patient for support.
- Bariatric chairs were not available should people require them within clinic waiting areas.
- We observed that information was available to patients about who to contact if they had any concerns about their care. Additionally there was a wide variety of information leaflets available in both waiting areas. We

asked staff and patients if information was available in different formats such as braille, large print or other languages. Staff and management confirmed that different formats were available if requested but were not readily available on site.

- We observed that the hospital provided disabled parking spaces within the immediate vicinity of the hospital. A toilet for those patients with a disability was located close to the waiting area.
- The outpatient department was on the ground floor and easily accessible for patients. The waiting area was spacious and allowed for easy access by wheelchair users. There were separate offices that supported staff and administrators and staff to have private discussion if need be. The services also had confidential interview and clinic rooms, which enabled staff and patients to have private discussions.
- We spoke with staff and patients who informed us that there was assistance for people who required additional support to communicate such as a loop system to assist in hearing and translation service for patients who would benefit from these services.
- For our detailed findings on access and flow please see the Responsive section in the surgery report

Learning from complaints and concerns

- The outpatient department displayed their complaints leaflet that informed patients of how to complain. However, this was available only in one format and one language.
- For our detailed findings on learning from complaints and concerns please see the Responsive section in the surgery report

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as **requires improvement.**

Leadership and culture of service

- Outpatients was led by the clinical services manager and patient services manager supported by the hospital director who reported to the Optegra UK national chief executive. Staff told us that local leadership within outpatients was good and managers were approachable, supportive and staff felt involved.
- There were lines of management responsibility and accountability within outpatient's department. Staff described who their line managers were and their individual roles and responsibilities.
- Staff in outpatients told us they worked well together as a team. Throughout the inspection, staff were welcoming and willing to speak with us. Staff spoke positively about the service they provided for patients. They were proud of their customer service and the way they worked as a team.
- For our detailed findings on the leadership and culture of this core service please see the well led section in the surgery report

Vision and strategy for this core service

- For our detailed findings on the vision and strategy of this core service please see the well led section in the surgery report.

Governance, risk management and quality measurement

- For our detailed findings on the governance, risk management and quality management please see the well led section in the surgery report.

Public and staff engagement

- For our detailed findings on public and staff engagement please see the well led section in the surgery report.

Innovation, improvement and sustainability

- For our detailed findings on innovation, improvement and sustainability please see the well led section in the surgery report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure they have robust systems in place to monitor the administration, management, storage and dispensing of medicines to provide safe care and treatment to patients.
- The provider must ensure that policies and guidance cover the range of risks to patients
- The provider must ensure that all staff have attended mandatory training and that there are sufficient numbers of staff with the right knowledge and skills to meet the needs of patients.
- The provider must ensure all staff and clinicians with practising privileges have the relevant checks when they commence and ongoing relevant training to ensure they have the required skills and knowledge to deliver effective care and treatment. The provider in line with the policy needs to keep revalidation with the general medical council due dates.
- The provider must ensure there is full adherence to the laser safety local rules.
- The provider must ensure tamper proof resuscitation trollies are put into use, and on surgery and outpatient clinic days checks of resuscitation equipment are consistently carried out in the outpatient department.
- The provider must ensure patients records are fully completed.
- The provider must ensure there is an effective system in place to monitor and take action to reduce risks to patients, in a timely way.
- The provider must ensure all clinical staff adhere to 'bare below the elbow' and there is consistent with the use of personal protective equipment in outpatients and diagnostics.

Action the provider SHOULD take to improve

- The service should ensure staff and managers are fully aware of the duty of candour processes, which incidents these apply to and how these should be implemented in practice.
- The provider should consider review theatre of the patient pathway standard operating procedure, to comply with the world health organisation (WHO) recommendations regarding the timing of the marking on a patient of the site to be operated on.
- The hospital should continue work with the Private Healthcare Information Network (PHIN) so that data submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- The provider should monitor and manage waiting times at the hospital to improve the experience for patients coming for treatment at the hospital.
- The provider should weigh patients so as staff can calculate their body mass index to be sure the equipment in place can meet their needs. Also, for staff to manage the additional challenges presented by these patients if they have intravenous sedation prior to procedures.
- The provider must take action to implement the requirements of the Workforce Race Equality Standards.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. Regulation 12 (2) (g) the proper and safe management of medicines The provider did not ensure nurses dispensing medicines were trained and competent to dispense medicines. The provider did not ensure medicines were stored consistently at the correct temperature in outpatients and diagnostics. Regulation 12 (2) (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. The provider did not ensure that all staff had undertaken basic life support training. Also mental capacity and deprivation of liberty safeguards training. Regulation 12 (2) (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way. The provider did not ensure safe use of the class 3B laser in a consulting room. The operating key we found left in the laser when room unattended, and a consultant had not locked the door and turned on the warning sign when using the laser. Checks of the resuscitation trolley equipment in outpatients and diagnostics were not always carried out when the hospital open. 12 (2) (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are healthcare associated.

This section is primarily information for the provider

Requirement notices

The provider must ensure all clinical staff adhere to 'bare below the elbow' and there is consistent with the use of personal protective equipment in outpatients and diagnostics.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (b) Assess, monitor and mitigate the risks related to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider did not ensure that effective systems and process were operated to enable the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2) (d) Maintains securely such other records as are necessary to be kept in relation to- 1. Persons employed in the carrying on of the regulated activity, and 2. The management of the regulated activity The provider had failed to implement safe recruitment and review procedures to provide assurance that all consultants working under practising privileges were fit and proper persons for the roles they were undertaking.