SpaMedica Ltd

SpaMedica Widnes

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Good ●

Summary of findings

Overall summary

We have not previously rated this location. We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. Most staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service with outcomes that were consistently significantly better than the England average when compared to other services. Mangers provided staff with opportunities to increase their skills and competencies. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Routine services were available five days a week although there was access 24 hours a day seven days a week to further support or treatment if needed.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Feedback from patients was consistently very positive.
- The service planned care to meet the needs of local people, took account of patients' individual needs, were focused on holistic person-centred care and made it easy for people to give feedback. Patient experience was important to the organisation as a measure of the outcome of treatments. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However;

- Not all staff had received training in key skills at the time of inspection.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Outstanding ☆	We have not previously rated this service. We rated it as outstanding. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to SpaMedica Widnes

SpaMedica Widnes is operated by SpaMedica Ltd and has been open since 2019. The hospital carries out cataract surgery, using local anaesthetic and yttrium aluminium garnet (YAG) laser eye treatments for adult patients referred from the NHS.

The hospital is located close to the town centre, in a business park with car parking facilities.

SpaMedica Widnes is registered to provide the following regulated activities:

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

The registered manager has been in post since January 2022.

There was one serious incident reported in June 2021.

The location has not previously been inspected.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out this unannounced inspection on 12 May 2022.

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 organisation understood and complied with the Mental Capacity Act 2005.

During the inspection, we visited outpatient and surgical areas. We spoke with 12 staff including registered nurses, health care technicians, patient co-ordinators, surgeon, and senior managers. We spoke with eight patients.

During our inspection, we reviewed six sets of patient records that covered cataract surgery and YAG laser. We reviewed three medicines administration charts.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

- The service consistently achieved significantly better clinical outcomes for patients when compared to other similar services.
- Patient stories could be viewed on the organisation's website along with a walk-through film of the service.
- Following a research programme, in the organisation, patients who were identified as high risk of post-operative infection could be administered a steroid injection on the day of surgery in addition to being provided with eye drops to take home.
- The organisation provided a free transport service door to door for patients who were travelling distances or unable to arrive by car.
- Community optometrists attended accreditation events so that patients could be followed up by them rather than returning to the hospital.
- The service supported local services and encouraged staff to be part of these with special events.
- The hospital was the North West location for the organisation of a 'dry lab'. Junior surgeons visited the site and attended training on false eyes to practise skills with equipment used in the theatre.

Areas for improvement

Should

- The service should ensure that all staff fulfil all mandatory training requirements in a timely manner. (Regulation 18)

Our findings

Overview of ratings

Our ratings for this location are:

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

Outstanding

Surgery

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

Are Surgery safe?

Good

We have not previously rated safe. We rated it as good.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. There were 23 staff at this location. Of these 19 out of the 23 (82.6%) had fully completed the statutory and mandatory training requirements. The remaining four had recently joined the organisation and were in the process of completing the courses included. The provider training compliance target was 95%.

The mandatory training was comprehensive and met the needs of patients and staff. There was a dedicated training team who supported and monitored training needs.

Training was a combination of online training and face to face.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff received safeguarding training level 2 for adults and children as part of mandatory training requirements. Hospital managers received training to level three. The clinical services manager had completed training to level four.

Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

There were safeguarding policies that included information which directed staff on how to respond and report concerns. We observed that all clinical rooms had relevant information displayed.

The organisation audited safeguarding training compliance quarterly. Between May 2021 and April 2022, results were on average 92.5% against the provider compliance target of 95%. The service had developed a safeguarding action plan to monitor results which included ensuring that staff new to the organisation completed training appropriately. Training compliance results had improved from 75% in March 2022 to 88.9% in April 2022. This was a mandatory training requirement for all staff new to the organisation.

Cleanliness, infection control and hygiene

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

Clinical areas were clean and had suitable furnishings which were clean and well-maintained.

All areas were visibly clean with schedules displayed. The cleaners' stores were observed to be compliant with national standards. We observed that the theatre environment including flooring, in all areas visited, had been designed with curved edging which complied with national standards for infection control in the built environment. We observed that walls had been coated with a damage resistant material which helped to minimise any infection risk. Patient chairs were wipeable and in a good state of repair.

There were measures in place to protect against COVID-19 that included clear signage and screens for social distancing. Patients were greeted by the porter who confirmed a lateral flow test had been taken, directed to apply hand gel and apply a fresh clinical mask. There were visors available for patients not able to wear a mask. Patients' temperatures were being checked, on arrival although this had now stopped and verbal confirmation of any symptoms checked.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were clinical sinks in rooms with hand washing instructions with hand sanitisers and clinical wipes freely available. There were 16 staff required to complete an infection prevention and control course as part of mandatory training requirements. Of these, nine (56.3%) had completed the course at the time of inspection. The service promoted international hand washing day in May 2022.

In theatre we observed staff adhering to social distancing measures and application of hand sanitiser and good hand washing technique. The organisation held records to show that maintenance checks had been routinely carried out. These included theatre air flow and legionella testing.

Staff were required to take routine lateral flow tests, twice weekly and had completed risk assessments following a furlough period. Additional infection, prevention and control training was implemented to support staff not fully familiar with working in a clinical environment.

Staff used records to identify how well the service prevented infections.

Staff cleaned equipment after patient contact. In theatre some items were identified as single use only and disposed of appropriately. For items that were re-used, there was a service level agreement with a third party for the decontamination of equipment. Equipment was prepared for the process with a bedside clean that followed national standards prior to being taken for decontamination.

Surgery

Between May 2021 and April 2022, there were no incidences of endophthalmitis. Endophthalmitis is an inflammation of the internal eye tissues, most commonly caused by an infection that is an ophthalmic emergency.

Hand hygiene and infection prevention were audited quarterly. Between May 2021 and April 2022, the average compliance was 98.5% for hand hygiene and 99.1% for infection prevention. The provider target was 95%. Results of audits were reviewed at the infection prevention committee where information about all locations was shared.

Environment and equipment

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

The design of the environment followed national guidance. The building was modern and there were three floors for the service. The service was accessed on the ground floor.

Patients were required to press a buzzer to gain access. Reception staff could see who had arrived as part of the close circuit TV for security purposes. The ground floor was for surgical activity with a clear pathway for patients from the waiting area in reception, through to surgery and then to the discharge area. The first floor was where the clinics were held for pre assessments and post-operative checks.

The second floor included staff only areas such as staff room, training areas and offices.

Access to all clinical areas was restricted with keypad or swipe access.

Patients could reach call bells and staff responded quickly when called. When patients were awaiting surgery, following eye medicines to promote dilatation of the pupil and marking the eye, patients waited in a communal area. Each space had a call bell with yellow signage to alert a staff member. This area was close to the reception area and including an emergency resuscitation trolley.

The service had enough suitable equipment to help them to safely care for patients. In the theatre, an emergency box for endophthalmitis was available. Endophthalmitis is an inflammation of the internal eye tissues, most commonly caused by an infection that is an ophthalmic emergency.

Staff carried out daily safety checks of specialist equipment. There were emergency resuscitation trolleys on both clinical floors as well first aid boxes held at reception desks. We saw that staff carried out daily checks of items on top of the trolleys with full weekly check of the contents of the trolley. Expiry dates were recorded in order to re-order replacements in a timely way.

All equipment had been electrically tested within the 12 months prior to inspection. The organisation held records of all equipment to show that maintenance checks had been routinely carried out. These included fire systems and alarms.

There was clear signage, in the event of fire with extinguishers available and maintained. Staff were required to complete fire training as part of statutory and mandatory training requirements. There were 13 staff who had completed fire marshal training.

There was an uninterrupted power supply (UPS) in case of a power failure. This was primarily for the theatre and fridges.

The service monitored the lenses that had been used and re-ordered the same lens to help prevent over stocking of items.

Cleaning kits were available in the event of any spillage. Any chemicals were stored in a locked cupboard identified for control of substances hazardous to health (COSHH) in a locked room.

The service had suitable facilities to meet the needs of patients' families. Due to COVID-19 relatives of patients were not permitted to wait except where a patient needed additional support.

Staff disposed of clinical waste safely. We observed that waste bags were compliant with national standards for the safe management and disposal of healthcare waste. Sharps bins were available, labelled and not overfilled. We did observe that the lids were orange rather than yellow. Orange lids would be expected for phlebotomy (taking blood samples) rather than general sharps.

Assessing and responding to patient risk

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

Clinical staff routinely accessed their electronic system to review any concerns highlighted about referred patients. This included imaging and patient information.

Where patients were identified with other health issues that required further treatment prior to their eye treatment, they were kept on a waiting list, which was monitored with advice available by an advanced nurse practitioner and the medical director. If needed the patients' NHS consultants were contacted for further information about other health conditions.

All surgery was performed under local/topical anaesthetic. The organisation did not use sedation or general anaesthetic. Any patients who were assessed and deemed unsuitable for local anaesthesia were referred back to the local NHS organisation, for example, patients identified who required a general anaesthetic or those with internal defibrillators.

On arrival for surgery, patient identity was checked and a name band applied. Staff completed risk assessments for each patient on arrival. These included checking of the patient's medical background, any allergies, any medicines taken as well as observations of vital signs and eye checks.

In the event of a patient collapsing at the location, staff called 999 for an emergency ambulance to transport to the local NHS hospital trust. Trained staff were required to complete face to face immediate life support (ILS) as part of mandatory training requirements. Of the eight staff required to complete ILS, four had completed (50%). Health care technicians and patient co-ordinators completed basic life support. There were 11 (68.8%) out of 16 staff who had completed practical BLS. There were 22 (95.7%) out of 23 staff who had completed a first aid course. At the time of inspection, staff who had not completed resuscitation training had recently joined the organisation. All were booked onto upcoming planned courses.

Staff completed eLearning as part of statutory and mandatory training. These included adult, paediatric and newborn resuscitation modules.

At pre-assessment patients needed to confirm they were able to lie on the theatre chair for the duration of the surgery. They were invited to attend a 'bed test' or try lying flat at home without pillows. If not able to tolerate then they needed to be referred back to the NHS hospital.

Outstanding ☆

Surgery

Patients identified as needing more complex surgery were referred to other locations with specialist surgeons.

Any known allergies were noted and clearly indicated in patient records. If a patient was identified with a latex allergy the patient was placed first on the list following a deep clean of the theatre the day before. Patients who were prescribed certain medicines were highlighted including warfarin or patients diagnosed as diabetic on the daily safety huddle in theatre. The huddle was audited quarterly. Between May 2021 and April 2022 results were 100% compliant.

We observed identification and allergy status checks when in theatre.

Staff completed the World Health Organisation (WHO) safety checklist for cataract surgery that had been adapted and improved following learning from incidents in the organisation. The WHO checklist is a simple tool designed to improve communication and teamwork by bringing together the surgeons, and nurses involved in care to confirm that critical safety measures are performed before, during and after an operation. We observed the use of the adapted ophthalmic surgical safety checklist and found completed appropriately. Surgical safety was audited quarterly. Between May 2021 and April 2022, there was an average compliance of 98.9%, against the provider target of 95%.

Following surgery patients had access to a 24 hour helpline for any concerns. If the concern could not be resolved verbally or the following day, on call staff were available to review a patient in an emergency situation. Patients were provided with a discharge booklet that included information about how to access support. The service audited urgent care responses quarterly. Between May 2021 and April 2022, the average compliance was 98.6% compliance, which was better than the provider target of 95%.

On discharge copies of the discharge letter were sent to the patient's GP and the community optometrist as well as sharing with the patient.

The organisation had developed a post-operative review service with accredited community optometrists. Four weeks following surgery patients attended an appointment in the community or at the service to review the results of the treatment.

There was a room designated for use of the yttrium aluminium garnet (YAG) laser treatment. (*YAG laser* is the laser used to clear any frosting from the back surface of a lens.) This treatment was carried out by an optometrist. Staff assigned were required to complete a core of knowledge course. Of the 13 eligible staff, ten (76.9%) had completed and one was in the process of completing. The environment had been adapted with the window covered over, no mirrors, specialised goggles for staff and patients, signage to indicate when laser was on and a lockable door. A fire extinguisher was close by outside the room. A set of local rules and risk assessments had been completed which included details of the laser protection adviser (LPA) and laser protection supervisors (LPS) as well as guidance on operating the laser. (An LPA is someone having sufficient skill in, and knowledge and experience of, relevant matters of laser safety, and able to provide appropriate professional assistance in determining hazards, in assessing risks, and in proposing any necessary protective controls and procedures. A LPS should be appointed to take day-to-day responsibility, on behalf of the employer, for maintaining safe laser use.) All YAG procedures were recorded in a register by the operator. The operator was responsible for the key for the laser. This was stored securely when not in use. Laser safety was audited quarterly. Between May 2021 and April 2022, there was 100% compliance.

Staffing

Outstanding ☆

Surgery

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

The service had enough registered nurses, optometrists and health care technicians to keep patients safe. These included the hospital manager, three theatre scrub staff, four trained nurses, one optometrist, seven health care technicians, six patient co-ordinators, and one porter.

Managers accurately calculated and reviewed the number and grade of staff needed for each day following a safer staffing tool. There was a standard staffing model for each part of the patient pathway. There was a minimum standard that the hospital followed dependent on the activity.

The service worked closely with another location for the organisation where staffing was monitored across the sites meaning that staff supported where needed to maintain safe levels and the appropriate skill mix.

Shortfalls in staffing were supplemented by regular agency staff who had been fully inducted in the services processes and competencies. These were regularly block booked for continuity of care.

Senior managers told us that if necessary the number of patients booked, on a particular day would be reduced and re booked in line with staffing numbers.

In the 12 months prior to inspection, four staff had left the organisation (14%). For the same time period the sickness rate was 1.2%. Recruitment activity days had taken place. At the time of inspection there were two vacancies for trained nurses.

Medical staffing

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

The service had enough medical staff to keep patients safe. All medical staff were consultant ophthalmologists. There were a combination of substantive staff and those working following practising privileges.

There was a practising privileges policy and the process was overseen by the medical director and the chief operating officer. Approvals of surgeons was agreed by the medical advisory committee following a period of supervised practice with a consultant lead mentor.

Consultants were included in the on call rota for any ophthalmic emergencies outside of hospital opening hours.

Records

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

Patient notes were comprehensive and all staff could access them easily.

Records were stored securely. Patient records were a combination of paper and electronic. Paper packs were stored in case of a computer failure. They were prepared a week prior to the patient attending. Following the pre-assessment clinic, any medical condition, medicines or allergies were highlighted as part of the individualised risk assessment process prior to surgery.

Following discharge, records were stored in cabinets in a locked room and then couriered to the head office location.

We reviewed records of six patients; three for patients who had undergone cataract surgery and three following YAG laser treatment.

Between May 2021 and April 2022, there were six records audits carried out. Target compliance was 95%. If this was not achieved the audit was repeated the following month. For two audits, results were 90.7% and 94.1%. We were shared an action plan; this showed that all actions had been completed and there was improvement to 98.7% and 98.9% for the re-audits. There was an average compliance of 96.3%.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up-to-date. Staff were required to complete medicines management awareness training. There was 95.7% compliance with one staff member in the process of completion.

Staff stored and managed all medicines and prescribing documents safely. All medicines were stored in rooms accessible only to staff in locked cupboards.

Fridge temperatures were checked, recorded appropriately and attached to an electronic system that alerted staff if the temperature was out of range.

We were shared an action plan following a medicines management audit. This showed that all actions had been completed.

There was a service level agreement with a medicines organisation that was a pharmacy. Stock was monitored with a system to identify when stock was due to be passed its expiry date.

The service used one controlled drug. This was stored securely and followed all processes around controlled drugs.

The service used patient specific direction's (PSD) for routine patient discharge medicines. (A PSD is an instruction to administer a medicine to a list of individually named patients where each patient on the list has been individually assessed by that prescriber.) The prescription for a list of patients was prepared a week prior to surgery. This was signed by the surgeon and forwarded to the medicine supplier to prepare. These were returned in sealed boxes for the day of theatre and locked in a cupboard within a locked room. Each patient had medicines that were individually labelled. The boxes included the manufacturer's instructions as well as written advice on administration of any eye drops. Patient medicines management was audited quarterly. Between May 2021 and April 2022, there was an average 98.4% compliance; the target was 95%.

Outstanding ☆

Surgery

For patients identified who may not manage to administer eye drops at home, such as manual dexterity issues, an alternative long-term injection could be given or district nurses could be requested to support patients.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The organisation used an electronic reporting system to report and record any incidents. How to log an incident on the system was part of mandatory training requirements. At the time of inspection 22 (95.7%) of 23 staff had completed this course.

Staff raised concerns and reported incidents and near misses in line with the organisations policy. Between December 2021 and May 2022, there were 16 incidents reported on the electronic system; all were reported as no harm and most related to COVID-19. No other themes identified.

The service had not reported any never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Managers shared learning with their staff about never events that had occurred at other organisation locations. Staff reported serious incidents clearly and in line with trust policy. The service used a root, cause analysis (RCA) approach to investigate serious incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

There was a 'sharing lessons' bulletin that was shared with staff about incidents that had occurred across the locations.

There was evidence that changes had been made as a result of feedback. We observed changes that had been implemented as a result of previous organisation incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

There was a policy and process for the management of national safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and the Central Alerting System (CAS). The director of clinical services and clinical governance lead received them and cascaded to the appropriate hospitals or departmental managers.

Are Surgery effective?

Outstanding ☆

We have not previously rated effective. We rated it as outstanding.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Outstanding ☆

Surgery

Staff followed up-to-date policies to plan and deliver high quality holistic care according to best practice and national guidance. We reviewed a sample of policies and guidelines and found that all were within their dates of review and complete.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At staff huddles, staff routinely referred to the psychological and emotional needs of patients. Patients' needs were assessed individually to ensure appropriate care and treatment was provided.

Any amendments to the patient pathway were reviewed at board level, through clinical effectiveness and operational meetings. When agreed they were then piloted and evaluated before cascading via area and hospital managers and to all staff within relevant departments.

The organisation was committed to a holistic view for the care for patients and recognised the impact of surgery on patients' daily living activities.

Following research by the organisations medical director, an injection during surgery, could be given as an alternative to discharge eye drops was introduced for certain groups of patients.

The location included a 'dry lab'. This was an ophthalmic training facility for junior doctors in the local area. It was the pilot location for the organisation, and the only facility in the North West. Surgeons used the same standard machines and consumables that were used in theatre but used synthetic model eyes.

Pain relief

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

Staff assessed patients' pain, following the surgery, and gave pain relief in line with individual needs and best practice.

We observed patients being told that they would not experience pain during the treatment but may experience some pressure. Pain relieving drops were given routinely, to all patients, during the treatment.

Patients were asked about pain following their surgery. Between May 2021 and April 2022, there was on average 91.2% of patients each month who reported a pain score of zero and 8.8% reported a score of one.

Patient outcomes

Staff were actively engaged in activities to monitor and improve the effectiveness of care and treatment. They used the findings to make improvements and achieved consistently good outcomes for patients. Opportunities to participate in national benchmarking were proactively pursued.

The service participated in relevant national clinical audits for ophthalmology.

Outcomes for patients were positive, consistent and met expectations, such as national standards. There were no incidences, in the six months prior to inspection where patients had needed to return to theatre.

Managers shared and made sure staff understood information from the audits.

Surgery

Clinical outcomes were published nationally via the Royal College of Ophthalmologist National Ophthalmic Database (NODA) audit. Data received showed the service had consistently had a significantly lower operative complication rate (posterior capsule rupture rate) of 0.47%, compared to the organisational target of 0.5% and a national average of 1.1%.

The location was benchmarked internally against other locations for the organisation and externally with other NHS organisations providing cataract care.

PCR is the most common potentially sight-threatening intraoperative complication during cataract surgery.

The organisation was also a member of the General Optical Council with qualified optometrists employed. It had been accredited and awarded gold by Investors in People that was due to expire in 2024. This is a service that provides advice and support in workplace culture and practices.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. The service recognised the importance of continuing development of staff skill, competence and knowledge as integral to ensuring safe care.

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

Managers gave all new staff a full induction tailored to their role before they started work. Staff were buddied up with a senior member of staff for support. The induction included all staff, spending time in a hospital in order to gain an understanding of the patient experience and journey through the hospital. This included non-clinical staff who worked in the organisation's contact centre.

Staff underwent a probationary period with regular meetings to support staff and review performance. They completed a new starter pack with the necessary competencies and assessments included.

Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff we spoke with reported they had participated in an appraisal in the 12 months prior to inspection and data received confirmed all had been completed.

A dedicated training team supported and monitored the learning and development needs of staff. They attended the location to support with one to one training and assessments. All training and competencies were standardised across the organisation. The service monitored the competencies achieved with a requirement to re assess every three years.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Outstanding ☆

Surgery

The medical director oversaw training and supervision for the medical staff. The organisation assessed clinical performance as well as bedside manner. Each surgeon was given a rag rating (red, amber or green) which was reviewed through governance processes with actions taken to address any shortcomings.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff were required to complete competencies applicable to their role prior to working independently.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Surgeons, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked with other agencies when required to care for patients such as community optometrists, district nurses and local clinical commissioning groups (CCG).

The location was also supporting NHS patients from another region to help with waiting lists in that area.

Patients were followed up either in the hospital or by a community optometrist four weeks following surgery where the outcome of the surgery was discussed with the patient.

Copies of the discharge letter were sent to the patient's GP and community optometrist as well as a copy offered to the patient.

The organisation included a facilities team who supported with any maintenance concerns.

There were drivers who transported patients in organisation mini buses to attend for appointments and surgery as needed.

There were service level agreements for certain services including medicines and decontamination.

Seven-day services

Key services were available seven days a week to support timely patient care.

The location was open Monday to Friday between 8am and 5.30pm. There was additional opening on Saturdays depending on the needs of the patients waiting.

Outside of normal working hours, there was an out of hours on call service. There were teams of staff allocated on a rota system in case of an ophthalmic emergency. There was also a senior manager on call rota to support hospital staff.

Patients were made aware, on discharge of the 24 hour helpline. If a call was received, these were passed to the on call team to determine the urgency. At the time of inspection if a patient needed to return, they were signposted to the head office location. There were plans to use this location for the same purpose to reduce travelling time both for staff and patients.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle considering both physical and mental well-being.

The services' website included information from patients regarding eye health that included wearing sunglasses, medicines and driving advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Mental capacity and deprivation of liberties was a training course as part of training requirements. At the time of inspection 17 staff (73.9%) had completed the course, five staff were in the process of completing.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. If a patient was assessed as lacking capacity to consent, an alternative consent form was used where a family member with Lasting Power of Attorney could provide consent.

Staff made sure patients consented to treatment based on all the information available. Interpreters or signers could be booked for consent purposes if needed.

Staff clearly recorded consent in the patients' records.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on the Mental Capacity Act. Dementia awareness was part of annual mandatory training requirements; this included Mental Capacity Act 2005.

We observed an optometrist gaining consent from a patient at pre-assessment clinic; it was informed and comprehensive.

Consent was confirmed again immediately prior to the treatment by the treating clinician to confirm that the patient still wanted to proceed with treatment.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Outstanding ☆

Surgery

Consent to share copies of the discharge letter post-surgery, with the patient's GP and community optometrist was obtained along with consent for surgery.

Between May 2021 and April 2022, quarterly consent audits were carried out. All results were above the target of 95%, with an average compliance of 99.3%.

Are Surgery caring?

Good

We have not previously rated caring. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

We observed good interactions between all staff and patients. They were welcomed into the building and spoken to in a way that put them at ease.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The service monitored performance of surgeons using a red, amber and green (RAG) rating system that included patient feedback.

Patients were routinely asked before discharge to give feedback on their experience and this was documented in the patient record. Patients were asked about their experience with the surgeon and the optometrist. This asked specific questions about their care and treatment and included if anything could have been done better. This data was collected and shared with the board and staff within the hospital. We received data from February 2022 to April 2022. There were 50 patient responses that all rated their overall experience as very good. Words used to describe the service included "exemplary, excellent, efficient, helpful, kind, caring, brilliant and professional."

Patients were given feedback cards and encouraged to provide feedback when they had returned home. The service monitored feedback from patients on an NHS website and responses were very positive and current.

Outstanding ☆

Surgery

Feedback was also received via social media sites which were shared with the organisation.

The accredited community optometrists who saw patient's as part of their follow-up care collected patient feedback for the service, to capture any further feedback.

Emotional support

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

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

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff putting patients at their ease particularly when they expressed feeling anxious.

There were chaperone posters displayed for patients who needed support. Doors to clinic rooms included signage to indicate if the room was occupied to prevent disturbance.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff we spoke with were clear about how the treatments resulted in positive outcomes for patients both physically and emotionally.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. If patients were unable to consent to treatment independently, those close to them could support them.

Staff talked with patients in a way they could understand. For patients, identified as vulnerable, someone close could remain with them.

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

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Are Surgery responsive?

Outstanding ☆

We have not previously rated responsive. We rated it as outstanding.

Outstanding ☆

Surgery

Service delivery to meet the needs of local people

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

The service was commissioned by the NHS to provide cataract surgery for the local adult population on a day case basis. There were no private patients seen at this location.

The organisation's centralised bookings teams managed the patient referrals on an electronic patient administration system.

Between May 2021 and April 2022, the service carried out 4,119 operations.

Patients chose to attend the service, including which location was preferable. Transport was provided if there was no location near to their home address.

The services' website had instructions about how to find the hospital whether arriving by car or public transport. It was located on a business park close to the town centre with free parking.

Patients were required to press a buzzer to gain access. They were greeted by the porter who completed COVID-19 checks with the patient.

Facilities and premises were appropriate for the services being delivered. The interior had been designed in line with other locations for the organisation to deliver this service.

There were waiting areas for pre-assessment clinic checks and a second waiting area for patients attending for surgery. Refreshments were available from hot drinks machines as well as water coolers in both areas. We observed staff offering and providing drinks to patients. Televisions were switched on in both areas.

Patients were required to attend for a pre-assessment clinic to ensure they were suitable for surgery. A date for surgery was given to the patient prior to leaving.

Managers monitored and took action to minimise missed appointments. Patients were contacted prior to surgery to confirm the appointment.

Managers ensured that patients who did not attend appointments were contacted. Staff contacted patients who had failed to attend to re-book or refer back to the NHS hospital. The GP was informed of any changes.

Meeting people's individual needs

The service was inclusive and proactively took account of patients' individual needs and preferences. Staff gave careful consideration to make reasonable adjustments to help patients access services. They coordinated care with other services and organisations.

Each patient was individually assessed at the pre assessment clinic. Any patient identified with reduced mobility or communication concerns had their needs assessed, recorded on the electronic patient record and a plan made to address any issues identified as necessary.

Surgery

There was an equality policy that included the management of patient's with a disability. This included an individualised risk assessment approach to assess and plan care in the best interests of the patient.

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which was accessible and promoted equality. This included people with protected characteristics under the Equality Act, and people who were in vulnerable circumstances or who had complex needs.

The service had information leaflets available in languages spoken by the patients and local community. There were also videos available that patients could view. Patient stories could be viewed on the organisation's website as well as a walk-through film of the hospital. Leaflets, about the procedures, were available in languages other than English and in larger fonts.

Managers made sure patients could get help from interpreters when needed. The service utilised an interpreter service if needed for patients whose first language was not English.

A lift was available to the upper floor. We were told that in the event of a breakdown, maintenance colleagues were very responsive. An evacuation chair was available if needed, including in the event of the fire alarm sounding. The stairs included yellow strips to guide patients with visual impairments.

Toilets were accessible for patients with mobility needs and the design was dementia friendly with contrasting wall colours to assist patients with a visual impairment.

Hearing loops were available on both clinical floors of the building for patients with a hearing impairment. Signers could be booked if needed for support.

There was a dementia lead for the service. Staff completed a module for equality, diversity and human rights as part of statutory and mandatory training. There were 20 (90.9%) of 22 eligible staff who had completed dementia awareness training. Of these nine had completed dementia champions training. We saw memory boards, in the waiting rooms, that displayed a range of cultural / social history. There was a memory box that included a range of puzzles / games / colouring activities and soft items that could be given out to patients.

For patients living with a learning disability or autistic spectrum disorder, they were offered additional visits, with those close to them, to help with preparations. For patients identified that needed a quieter environment, these could be accommodated in quiet rooms. For patients unable to tolerate a face covering these waited away from other patients.

For patients identified with claustrophobia, alternative clear drapes were available, or these could be pulled away to provide space.

For patients who were unable to self- isolate for 10 days, free COVID-19 polymerase chain reaction (PCR) tests were offered on an individually assessed basis prior to surgery.

For patients identified who may not manage to administer eye drops at home, such as manual dexterity issues, an alternative long-term injection could be given or a request for district nurse support would be made.

The service had an incontinence box in case of an emergency so that patients were fresh when going home.

The service collected glasses, no longer needed. These were forwarded to a local opticians and re-used.

Prior to COVID-19, the service donated single use blankets to the local guide dogs charity that supported visually impaired people. There were plans to re-start this. More recently patients were encouraged to take the blankets home. They had previously been visited by a guide dog and their owner to share their story.

The service had supported a number of charities that included Christmas jumper days and red nose day, and dog walking for a dementia charity. There were leaflets available that signposted to charities / helpline services that patients may choose for additional support, this included telephone befriending.

Staff planned patients' discharge individually. This included those who were in vulnerable circumstances or who had complex needs. All patients had a discharge consultation with a registered nurse after their procedure. We observed a discharge consultation and saw patients were given appropriate guidance and information both verbally and in writing. Staff made sure patients were safe to leave and travel home.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Between May 2021 and April 2022, patients waited an average of four weeks to be seen by the service against an NHS target of 18 weeks.

Managers and staff worked to make sure patients did not stay longer than they needed to. The organisation had secured a contract for patients, in another area to help support waiting times in that region.

The service monitored patients who failed to attend. Between May 2021 and April 2022 there was an average of 1.1% of patients who failed to attend each month. These were contacted to check welfare and re-book if the patients chose this. If unable to contact, the GP and referrer were informed for follow-up.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. All complaints were investigated in line with the company complaints policy and discussed within hospital and department team meetings. The clinical governance committee was responsible for reviewing themes and trends from any complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Between December 2021 and May 2022, the service had received one complaint. The response was reviewed during the onsite inspection and found to be completed appropriately.

Outstanding ☆

Surgery

Conflict resolution was a module included in the statutory and mandatory training.

Patients were signposted to the Parliamentary and Health Service Ombudsman (PHSO) if not satisfied with the complaint response.

Are Surgery well-led?

Good

We have not previously rated well-led. We rated it as good.

Leadership

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

There was an organisational structure with a chief executive, chief operating officer, medical director and head of clinical services. These were supported by other senior managers that included infection, prevention and control leads, regional directors and an advanced nurse practitioner. These supported area managers and location hospital managers. The hospital manager was the CQC registered manager. Senior staff were recruited with the required skills to undertake and manage their service. Senior leaders routinely visited the location when support was needed and said they were visible and approachable.

The organisation supported hospital managers, new to the role with staff encouraged to develop their skills internally as well as external recruitment processes.

The organisation had a centralised human resources team that monitored compliance with the Fit and Proper Person Requirement (FPPR) of the Health and Social Care Act. This regulation ensures that leaders have the essential skills and competencies to manage an organisation.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services.

The vision and values were displayed on the trust website.

The organisation's vision was 'every patient, every time: no exception, no excuses'.

There was a focus on three objectives of "patient safety, excellent care and patient satisfaction."

The strategy for the organisation covered five main areas which were growth, quality, leadership, governance and infrastructure.

Outstanding ☆

Surgery

Culture

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

The organisation was committed to the patients experience being positive during their care and treatment. Any concerns that were outside their expertise were signposted or referred to other stakeholders to be followed up.

All staff we spoke with enjoyed working at the location and for the organisation. There was good teamwork across all staff roles and we were shared examples of staff supporting each other.

Staff were encouraged to raise any concerns they had. We saw where managers had worked with staff to support them and resolve issues. Workplace bullying was included in mandatory training requirements. At the time of inspection, 21 (91.3%) out of 23 staff had completed the course and one was in the process of completing.

The organisation supported staff to progress within the organisation and increase their competencies. Senior managers told us the results of the staff survey had been shared. They identified a theme related specifically to health care technicians that was being addressed by the senior team.

Governance

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

The organisation had a clear governance structure that identified areas of responsibility. There was a commitment to ensuring relevant information discussed at board level was disseminated through to local hospitals. This occurred via area managers who had weekly meetings with the senior team.

The procedures carried out at the location had all been commissioned by the clinical commissioning groups for adult patients receiving care and treatment via the NHS.

All meetings included attendees, regular agenda items and actions identified including progress.

The national clinical governance meetings and clinical effectiveness meetings were held bi-monthly. Governance meetings reviewed any serious incidents and identified any themes / trends, clinical outcomes, policies, the risk register, any infection, prevention and control concerns and patient satisfaction scores.

Learning from serious incidents, across the organisation were discussed at the clinical effectiveness meetings and then cascaded to hospitals. The infection prevention committee met quarterly and discussed regular agenda items. These included any changes in national guidance, updates from facilities and audit results across locations. There was also the health, safety and environmental committee and the water committee.

There was a medical advisory committee that had quarterly meetings and reported to the board. Surgeon outcomes, both clinical and patient reported were reviewed on a quarterly basis at the clinical governance meeting and the medical advisory committee (MAC). Practicing privileges were reviewed and discussed regularly at MAC including if a specific concern had been raised. All surgeons had a General Medical Council (GMC) responsible officer and were required to share their appraisal outcome to the organisation.

Surgery

We reviewed recruitment files for five members of staff of different grades and qualifications. These were maintained centrally but on the day of inspection we viewed documentation electronically. We found that staff were required to complete a range of documentation including identification, qualifications, if any, health checks and enhanced police checks with the Disclosure and Barring Service.

The medicines management committee met quarterly to review processes, policies and training needs aligned to national guidance. There was an operations committee that met monthly to discuss all areas of hospital activities. These included hospital managers in addition to the senior management team.

The organisation had service level agreements in place (SLA) with third party organisations. These included medicines provision and decontamination of surgical instruments.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Senior managers told us that the three top risks were staffing, COVID-19 and falls. There was an action plan to monitor these locally.

There was a local risk register that was aligned to the national corporate risk register. All risks had recently been reviewed with control measures in place that had been assessed as adequate. Most of the risks were associated with patient safety.

Organisational audits took place at all locations monthly that were aligned to Care Quality Commission key lines of enquiry. Action plans were included for any audits below expected targets.

The organisation had developed a peer review programme which included hospital managers reviewing another location bi-annually to ensure standardisation and sharing any good practices. An action plan was developed following the location review, in September 2021. We saw that all actions had been completed. Results were reviewed at quarterly operational meetings.

Surgeon's performance was monitored using a red, amber, green (RAG) rating system. This included not only the skill level but interactions with patients. Staff were also given an opportunity to feedback. Any concerns were addressed by the medical director and the medical advisory committee.

The organisation's public and employer indemnity insurance certificate was displayed in the waiting room area.

There was a business continuity plan that was applicable to the location.

Information Management

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

The organisation had an electronic system that included a 'live dashboard' of performance across the locations. Senior managers analysed the data in the dashboard to benchmark across locations and make improvements where needed.

Patient records were a combination of paper and electronic that were managed well. In the event of computer failure, essential information could initially be captured on paper.

Organisational policies and guidelines were stored in the electronic system. Staff were allocated individual login details to access information and ensured information was not visible when left unattended. There was a requirement for staff to read, when updated. The system monitored the time staff accessed the policies.

Any safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and the Central Alerting System (CAS) were received by the director of clinical services and clinical governance lead and cascaded to the appropriate hospitals or departmental managers.

There was a process to submit statutory notifications to the CQC and we received a notification following an incident.

The organisation submitted 100% of data to the National Ophthalmology Database Audit (NODA).

The statutory and mandatory training included modules on data security awareness and data protection.

Staff completed training in countering fraud, bribery and corruption. At the time of inspection 22 (95.7%) of 23 staff had completed the course.

The information governance committee reviewed any concerns.

Engagement

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

The organisation's website included information about upcoming community events such as conferences. There were videos of patient who shared their experience at the service as well as a video of the journey through the hospital for the pre assessment clinic and the day of surgery. Patient leaflets, about procedures were available to request via the website.

The organisation engaged with local commissioners regarding the service and monitored Covid-19 requirements as needed following the first 'lock down' period.

The organisation held staff forums with representatives from different locations and grades of staff so that they could air any concerns. Patient co-ordinators had shared they would like the choice of wearing trousers as part of their uniform. They had also requested holders for patient drinks. There were weekly email updates which included 'feel good Friday'. This included examples of positive information such as any patient feedback.

The location had received a selection of gifts including chocolates, biscuits and cards from patients.

There were regular communications from the chief executive. Feedback was shared from board to the floor and back to the staff. There were monthly team meetings held. These discussed all aspects of hospital activities that included national updates and other information that needed to be shared.

Staff were encouraged to nominate their 'office hero' colleagues accessible via QR code using smart phones. Locations held events to share with colleagues that included pizza and donuts.

Recruitment events were held to attract staff as well as accreditation events for community optometrists.

Following successful completion of the probationary period, staff were remunerated with two bonuses a year.

If a staff member was called out, overnight unexpectedly, they were automatically given the next day off work.

At times if a staff member needed to work at another location, the organisation would either provide a taxi or provide travel expenses.

The location maintained a folder that highlighted staff successes as well as events to raise funds for local charities such as cake sales. One of the health care technicians took in drinks and chocolates to recognise the work of the patient co-ordinators on national receptionist day. They had celebrated international women's day. They had completed a week of 'a day in your shoes' when the manager, at the time, experience a day in different roles of patient co-ordinator, porter and housekeeper.

Staff at the service had participated in mental health awareness week in May 2022. They were encouraged to share their top tips to support mental health with each other.

There were a number of leaflets available that signposted patients to local charities that they could contact as part of the response to being isolated during the COVID-19 lockdowns or shielding periods.

Information shared from the macular society at other locations was shared across the organisation. This included the decoration of toilet facilities so that for patients with visual impairments can distinguish between furniture and wall decorations.

Prior to COVD-19, single-use blankets provided in theatre, were donated to the local guide dogs for the blind. A tea party was held by staff to raise funds for these guide dogs. The location collected spectacles no longer required following surgery and donated them to a local optometrist for recycling abroad.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The organisation was committed to providing a service that was continually evolving and improving as a result of learning or research.

The medical director had conducted a number of research programmes and had presented nationally and internationally as well as published in recognised health journals. He was passionate about excellent outcomes for patients that included the surgery and their experience with staff. It had been identified that certain demographic groups responded better to some discharge medicines than others.

The organisation had developed an alternative to the administering of eye drops, on discharge. They could administer an injection, during the surgery, that was long-lasting. This was given following assessment for suitability and appropriateness.

Outstanding ☆

Surgery

The organisation supported junior doctors in the local areas with ophthalmic training in a 'dry lab'. It was the first 'dry lab' for the organisation, as the pilot, and is the only one in the North West. This included all the equipment utilised during ophthalmology surgical procedures. It used the same standard machines and consumables that were used in theatre. The Dry Lab used synthetic model eyes that replicated the feel, texture, and characteristics of a human eye with cataracts.

The organisations surgeons were offered access to this laboratory during the first COVID-19 lockdown when theatres were closed. It was now being used by NHS trainee surgeons to provide surgical simulation. If necessary, the equipment could be loaned to other locations in case of an unexpected failure.

The organisation routinely provided discharge medicines using patient specific directions (PSD). This location was the pilot, for the organisation, prior to implementing to all areas and locations.