Essex Vision at Westland Medical Centre

Quality Report

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Date of inspection visit: 11 December 2017 and 21 December 2017
Date of publication: 18/05/2018

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

Ratings

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

Overall summary

Essex Vision at Westland Medical Centre is operated by Essex Ophthalmology Services Ltd. The provider is based on the first floor of a two storey purpose built building. Facilities include a minor operating theatre, laser room, two consulting rooms and outpatient and ophthalmic diagnostic facilities.

The service offered a range of ophthalmic treatments and surgery for conditions such as glaucoma, medical retina disease, diabetic retinopathy, corneal disease, macular disease, oculoplastic procedures, and orthoptics (treatment of the irregularities of the eyes).

Summary of findings

The service provides surgery services and outpatient and diagnostic imaging for a number of eye conditions for patients over the age of 18. We inspected these services under the frameworks for surgery and outpatient inspections.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 11 December 2017 with an unannounced visit to the service on 21 December 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 service 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.

Services we rate

We rated this service as good overall.

We found good practice in relation to surgical care:

- Patients received care in visibly clean and suitably maintained premises and their care was supported with the right equipment.
- The service used evidence based practice from the National Institute of Health and Care Excellence and the Royal College of Ophthalmologists.
- The service was well staffed and all staff had undertaken mandatory training including appropriate safeguarding training. There was no agency staff used.
- The consultants worked well together and provided cover for each other if necessary.
- Access and flow of patients through surgery was well managed with processes in place to minimise the risk to patients. Patient feedback was good and the service provided quality care to patients.
- Leadership was strong from senior staff and from consultants with regular meetings to review and disseminate information and patient related issues to staff.

We found good practice in relation to the outpatients service:

- The outpatient department (OPD) processes for referral into the service worked well and the provider was able to allocate appointments in a timely manner due to the efficiency of the systems in place and referral to treatment times were always less than two weeks. This ensured patients were able to access care rapidly.
- Referrals to the service reduced outpatient appointments at local hospitals, and offered patients a more accessible service in the community with lower waiting times.
- Staff took a patient-centred approach in the interactions we observed and regularly asked the patient if they could be made more comfortable
- The service would regularly run Saturday and Wednesday afternoon clinics to facilitate working patients and elderly patients who would require family members to attend with them.
- There were procedures in place for safety of the use of lasers in the OPD. Fire safety was part of the induction process and risk assessments had been completed to reduce the risk of fire in all parts of the service.

However, we also found the following issues that the service provider needs to improve:

- The application of the duty of candour was not included in the incidents policy.
- Additional audit activity needed to be developed for patient outcomes.
- There was no information available for patients whose first language was not English.
- Laser protection protocols were not signed as read by consultants working with the service.
- The resuscitation bag was not sealed and tamper proof.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. On our unannounced return we found some improvements had been actioned.

Summary of findings

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	Good	Surgery was the main activity of the service. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with outpatients. We rated this service as good because it was safe, effective, caring, responsive and well-led. There were processes in place to reduce the risk of harm to patients. Staffing was appropriate and there was no use of agency staff. Access and flow of patients through surgery was efficient. Patient safety and patient experience were the focus of the service. Staff had all undertaken mandatory training and had completed the appraisal process. There was effective medical and senior team leadership at the service.
Outpatients and diagnostic imaging	Good	We rated this service as good because it was safe, effective, caring, responsive and well-led. Referral to treatment times were good and the service had systems in place to ensure that patients were seen in a timely manner. Staff were very caring and patient feedback about the service was positive.

Summary of findings

Contents

Good

Location name here

Services we looked at:
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Essex Vision at Westland Medical Centre

Essex Vision at Westland Medical Centre is operated by Essex Ophthalmology Services Ltd. The service opened in February 2014. It is a private service in Hornchurch, Essex. Services are mainly provided for the Havering clinical commissioning group (CCG) and also some of the surrounding CCGs including Barking and Redbridge.

Essex Vision offered a range of treatments and surgery for conditions such as glaucoma (a condition of increased pressure within the eyeball, causing gradual loss of sight), medical retina disease, (treatment of the back of the eye), corneal disease (treatment of the cornea at the front of the eye), macular disease(condition that leads to the gradual loss of central vision), oculoplastic procedures (conditions of the eye lid and tear drainage systems) and orthoptics (treatment of the irregularities of the eyes).

Referrals to the service were made by GPs and optometrists for patients requiring primary care and selective secondary care for eye conditions. The service worked closely with a local NHS trust where tertiary referrals and stable low risk conditions were transferred to community services.

The service has had a registered manager in post since May 2014.

Our inspection team

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

Information about Essex Vision at Westland Medical Centre

The service is registered to provide the following regulated activities:

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

During the inspection, we spoke with seven staff including; registered nurses, reception staff, medical staff and senior managers. We spoke with six patients and one relative. During our inspection, we reviewed eight sets of patients' records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. This was the services first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (September 2016 to August 2017)

- In the reporting period September 2016 to August 2017 there were 5,911 day case episodes of care recorded at the service which were all NHS-funded.
- There were 5,264 outpatient total attendances in the reporting period; of these 100% were NHS-funded.

Track record on safety

- No never events
- No clinical incidents
- No serious injuries

No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),

No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (c.diff)

No incidences of hospital acquired E-Coli

Summary of this inspection

No complaints

Services provided under service level agreement:

- Clinical and or non-clinical waste removal
- Grounds Maintenance
- Laser protection service
- Maintenance of medical equipment
- Electrical testing maintenance

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There were policies and procedures to support the reporting of incidents and staff knew how to report incidents of all severities.
- Equipment was serviced regularly and all electrical tests had been completed and were in date.
- Staff followed infection control procedures and the service was visibly clean.
- All staff had completed mandatory training including safeguarding training to an appropriate level for their role.
- There were processes in place to reduce the risks to patients undergoing surgery at the service and there were arrangements with an NHS provider in case of a patient requiring emergency treatment. Systems were in place to support patients following surgery.

However, we also found the following issues that the service provider needs to improve:

- We found that the resuscitation bag was unsecured and not tamper proof.
- The duty of candour needed to be included in the incidents policy
- The laser protection protocols were not signed as read by consultants working within the service.

Are services effective?

Good

We rated effective as good because:

- The service used guidance from the National Institute of Health and Care Excellence and the Royal College of Ophthalmologists
- Additional training was provided to staff using laser equipment, which ensured patient procedures were carried out safely.
- The process for granting practising privileges was robust, consultants working at the service had completed their appraisals and there was evidence of continuous professional development.

However, we also found the following issues that the service provider needs to improve:

- The service did not contribute outcome data to the national ophthalmic database.

Summary of this inspection

- The service was not undertaking regular audits of surgical outcomes to monitor the quality of care being delivered.

Are services caring?

Good

We rated caring as good because:

- Staff reassured patients throughout their treatments and feedback from patients was very positive.
- Patients said they were treated with privacy and dignity at all stages of their treatment.
- Patients were involved in the planning and delivery of their treatment and care.
- 100% patients stated in feedback questionnaires they would recommend the service to a friend or family member.

Are services responsive?

Good

We rated responsive as good because:

- Access to services was well managed and waiting times for treatment were kept as low as possible.
- The flow through surgery for patients was streamlined allowing procedures to be carried out in an ordered way maximising available resources.

However, we also found the following issues that the service provider needs to improve:

- Patient information on how to make a complaint did not include information about the Optical Complaints Consumer Service.
- Patient information leaflets were not available in different languages or formats.

Are services well-led?

Good

We rated well-led as good because:

- There was effective teamwork and good leadership, which created a positive culture.
- There was a good system for patient feedback.
- Staff told us they were well supported and they were able to give feedback.

However, we also found the following issue that the service provider needs to improve:

- There did not appear to be a vision or strategy.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

The main service provided by this service 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 section.

We rated safe as **good.**

Incidents

- There were generally effective processes in place for reporting and managing incidents. There was an incident reporting policy at the service which outlined the procedure for the reporting of incidents. The incident reporting system was a paper based system. There were no incidents reported in the surgery department within the reporting period.
- The service reported no never events in the reporting period between September 2016 to August 2017. Never events are serious incidents that are entirely preventable as guidance or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Staff we spoke with were aware of the incident policy and knew how to report incidents. Incidents were discussed as part of clinical governance meetings every two months. Clinical governance meetings included representation from other healthcare providers on the site, which allowed learning from incidents to be shared between services. Once incidents had been discussed the information was shared at staff meetings. The service did not monitor if staff had received any training in root cause analysis for incidents.
- 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.
- Although duty of candour was not specifically identified in the incident policy and staff training in duty of candour was not monitored, staff said that they would always apologise to patients if something went wrong during their treatment. The service managers were aware of the principles of duty of candour, however did not specifically monitor if their staff had duty of candour training.

Cleanliness, infection control and hygiene

- The service had an infection prevention and control policy (IPC) with sections on hand hygiene, clinical waste, blood spills, cleaning of equipment, and management of patients who may require isolation. The policy also identified the clinical director and practice manager as responsible for ensuring compliance with infection control practices.
- Mandatory training records showed that all clinical staff working for the service had completed infection control training. Data supplied demonstrated 100% compliance with hand hygiene. We observed staff adhered to IPC policy during our inspection, including cleaning their hands after patient contact and arms bare below the elbows.
- The service employed an external company to annually review infection control practices. This included an

annual visit evaluating standards of cleanliness, hand hygiene, infection control, and management of clinical waste. The most recent report, from December 2017, stated compliance with all standards of cleanliness and infection control across the service.

- All areas we inspected appeared visibly clean. Staff were observed to record inspection and cleaning of clinical areas following completion of daily clinics. We reviewed logs of cleaning rotas and found this was completed every day.
- We found hand sanitising gel dispensers in use in communal and clinical areas throughout the service. We also observed posters located in clinic rooms and waiting areas encouraging visitors to use the gel dispensers.
- Sharps bins were in place, dated, signed and off the floor in all areas, we visited. This reflected best practice guidance outlined in the Health and Safety Executive (HSE) The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Sharps bins were used by clinical staff to safely dispose of used instruments such as, syringes, needles, and glass ampoules.
- Instruments used for treatment were single use and were disposed of after treatment.
- During the reporting period, there were no incidents of MRSA or MSSA and there were no cases of Clostridium difficile (C.diff) or E.coli infections.

Environment and equipment

- The service maintained emergency resuscitation equipment on site. The bag was kept in the minor operation clinical room where surgical interventions were performed. The bag was checked on a weekly basis. We checked the resuscitation bag and found no security tags in place to secure the contents and protect unauthorised access to controlled medications. We found that no items were missing from the resuscitation bag. We raised this with the service and on the unannounced inspection we saw the resuscitation bag secured with security tags.
- We saw that equipment was serviced regularly and according to the manufacturer's specifications. We checked portable appliance testing (PAT) on a selection of electrical equipment and found this to be in date.
- There were two clinical treatment rooms, one for minor operations, and a laser treatment and diagnostic room. The service also had a two consultation rooms for patients to meet with consultants. The service was able to provide YAG and argon laser treatment to patients.
- There was appropriate signage on the doors for laser equipment and oxygen storage. There were lights to indicate that lasers were in use, and laser treatment was carried out in dedicated rooms.
- The laser used in theatre for refractive eye procedures required staff to wear safety goggles. These were in good condition and staff were able to tell us the importance of their use. We saw completed laser risk assessments.
- Local rules were in place for the safe use of lasers in the service and we saw a list of authorised laser users. However we found that authorised users had not signed to confirm that the local rules had been read and complied to. We raised this with the Medical Director, who stated the rules had recently been revised and it would be actioned as a matter of urgency.
- There was an external company who provided laser protection advisory services. The service had a laser protection advisor report completed in October 2017. The clinical director for the service was identified as the laser protection supervisor, and consultants had laser safety training.
- All flooring was easily cleanable and in accordance with Health Building Note (HTM) 00-10 part A: Flooring. All work surfaces appeared to be clean and were clutter free.
- All surgical instruments used were disposable and stored appropriately. The practice manager monitored stocks of equipment and reordered as necessary.

Medicines

- There was a medicines policy for the service which was in date and had a review date. We observed practice to be in line with the policy as outlined.
- Medicines were stored appropriately in a locked cabinet. The practice manager ordered all stock medicines and they were responsible for the disposal of out of date medicines. We observed the daily log of medications completed by the practice manager.
- The service had an arrangement with a local pharmacy to provide medication stock and support when needed, or emergency descriptions if needed.

- Stock was monitored and staff used the stock with the closest expiry date first to reduce any medicines wastage. Eye drops were stored appropriately and fridge temperatures were monitored and recorded. Records showed that medicines had been stored at the correct temperature.
- We were told that nurses administered eye drops as per consultant recommendation and this was recorded in medicines administration charts in the patient records. Eye drops were dispensed by ophthalmic nurses following treatment, along with information on how to use the eye drops appropriately.
- The service provided the patient's first prescription for eye drops free for certain conditions such as glaucoma management. This stopped the delay in initiating treatment and enabled the patients to access necessary medication without additional cost.
- Oxygen was available in theatre areas and the provider had a contract for the disposal and replenishment of the oxygen cylinders. Oxygen cylinders were secured to the wall and checklists were attached to them.
- There were no controlled drugs in theatres.

Records

- The service had a policy for the management of clinical records. The service used paper records which were kept on-site in locked filing cabinets in a secure room.
- We looked at eight sets of patients' records and found theses to be legible and up to date. Records included a full patient medical history, allergy status and results of any tests.
- The service carried out an annual audit of patient records to be assured notes were being appropriately completed. The most recent audit in March 2017 found that clinical records were generally well maintained and completed.
- Surgeons completed their notes in the patient's record following each procedure. Following surgery each procedure was noted in the register of operations.
- We reviewed records of an adapted World Health Organisation WHO five steps to safer surgery checklist which included procedure check, check of relative eye dominance, allergy check, and equipment and instrument check. The two members of staff present in the treatment room had signed all checklists.
- There had been an audit of records and WHO safety checklist in March 2017, and results had been discussed positively at the following clinical governance meeting. We were told that a new WHO form had been devised and would be implemented at the beginning of the year.
- Referral forms the local NHS acute trust or from community sources (GPs or optometrists), were retained in the patient records.

Safeguarding

- The service did not provide treatment to young people under the age of 18 and young children were not allowed in the treatment area.
- The service had a safeguarding policy, which described the types of abuse, and concerns staff should report.
- Staff we spoke with had an understanding of safeguarding. Any safeguarding concerns were reported to the clinical director, who escalated these to the local authorities.
- Training in safeguarding in both adults and children was incorporated in the mandatory training schedule for all staff. The training figures provided on inspection showed that all medical staff were compliant with this training, however three of five nursing staff had not provided the necessary certificate of safeguarding training despite completing the course.
- There were no safeguarding concerns relating to this service reported to the Care Quality Commission (CQC) in the reporting period of September 2016 to August 2017.

Mandatory training

- Mandatory training included basic life support (BLS), equality and diversity, fire safety, safeguarding of children and young people and adults, health and safety, infection prevention and information governance. This training was completed annually and was a mixture of e-learning and face to face learning.
- All staff were compliant with their appropriate mandatory training requirements, which included basic life support, infection control, safeguarding, information governance, and equality and diversity. Staff told us they were given time to complete their on line mandatory training. Staff reported that if they complete any on-line mandatory training that the time was given back to them to take as time off in lieu.
- Staff told us they had completed annual basic life support training. The majority of staff were not trained

to an immediate or advanced level of life support, as the treatment provided at the service did not include the use of general anaesthetic. The service's policy was to provide basic life support until the emergency services arrived.
- In the event the laser machine was upgraded or in light of new improved ways of working the machine manufacturer had a dedicated team of trainers who delivered training to staff.

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

- Referrals were made to the service by a general practitioner (GP) and opticians. Forms with the patients' medical details such as comorbidities and allergies were faxed using a secure line to the service. The form would be triaged by the consultant and the appropriate clinic would be recommended. Less stable and high-risk patients were referred to a local hospital.
- Staff told us deteriorating patients would be managed in line with the service's resuscitation policy. The policy stated the patient would be attended to by a consultant and the emergency services would be called. Consultant training records showed each member of medical staff had up to date basic life support training. No patient had been transferred out of the service due to deterioration since it had opened.
- The service carried out minor operations such as excisions of benign lesions of the eyelid. Laser treatments were carried out on patients with glaucoma and on patients after cataracts surgery. The service treated patients with local anaesthesia. The service did not use sedation or general anaesthetic.
- The service operated Monday to Saturday, with Tuesday and Thursday opening until 7 pm. Glaucoma patients were primarily operated on Saturday as the service stated it was easier for patients to be escorted.
- Staff used an adapted 'five steps to safer surgery' World Health Organisation (WHO) checklist to minimise errors in treatment, by carrying out a number of safety checks before, during, and after each procedure.
- A laser protection supervisor was always present throughout the patient's treatment.
- Post-operative patients were assessed by a registered nurse. They were provided with written instructions for aftercare and follow up appointments. We observed a nurse provide aftercare instructions to a patient. The discussions were informative, clear and provided useful information for after care. Patients were given an out of hours telephone number to use if they had any concerns following treatment.
- The surgeon was available in the 24-hour period following the procedure. Managers told us that there were back up surgeons available in the event that the operating surgeon was not available, for example to cover illness or annual leave.

Nursing and support staffing

- There were six nurses at the service, four of which were ophthalmic trained. In addition there was one health care assistant and a fully qualified visual field technician.
- There was low staff turnover at the service. There were no staff vacancies at the time of our inspection and the service did not use agency staff.
- Clinical staff rotas were dependent upon the number of surgical procedures booked for that day. Staff we spoke with told us they were satisfied that they received their rotas with enough notice.
- An external company provided the Laser Protection Adviser (LPA). Staff told us they were easy to access and the organisation had a good professional working relationship with them. We reviewed evidence of their input into training for core skills knowledge.
- The registered manager was the service's named Laser Protection Supervisor (LPS). We were told the manager was always on site during surgical days.

Medical staffing

- There was one consultant employed full time by the service, who was also the registered manager and Medical Director. There was a further five doctors practising under privileges at the service.
- Following surgery patients were given contact details of the service. Patients were told to contact the service between the hours of 8am and 8pm Monday to Friday where a nurse would take the contact details and brief description of concerns. The nurse would then make contact with the relevant consultant who would contact the patient. Patients were advised if an emergency occurred between 8pm and 8am Monday to Friday and at weekends to attend the local hospital and contact the service or consultants secretary the next working day.

Good

Surgery

- The service operated a buddy system where a consultants leave would be covered by a named colleague. Staff were able to show us the up to date consultant cover list.
- The Professional Standards for Refractive surgery 2017 state that refractive surgeons should either hold the Certificate in Laser and Refractive Surgery (CertLRS) or be on the General Medical Specialist Register in Ophthalmology, and hold evidence in their last revalidation cycle of an established refractive surgery practice. All the surgeons at the service complied with these standards.

Emergency awareness and training

- There was a contingency plan for major failure including a power cut, a failure of the telephone system and an information technology failure.
- The provider had installed an uninterrupted power supply system (UPS) that activated automatically in theatre if there was a break in the electric supply. The UPS system would supply a continuous supply for the laser machine and all wall sockets within the theatre for 30 minutes giving the surgeon and staff a safe period of time to complete or ensure surgery was completed to a safe point.
- The induction policy for new staff included information about evacuation procedures and the fire drill and the fire alarm system.
- The lift could be operated manually in the event of a power failure and staff knew how to do this.
- Emergency exits were well signed and there were fire extinguishers that were appropriate to the type of fire that could occur. These were all in date.

Are surgery services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- The service worked to guidelines from the National Institute of Health and Care Excellence (NICE) and guidelines from the Royal College of Ophthalmologists. Policies and procedures were in date and staff were able to access these online and in paper form.
- Pre-operative tests for elective surgery were in line with NICE guidelines NG45. Patient's medical history was discussed and appropriate tests and scans were taken to help determine treatment.
- We were told when new guidance came out from national bodies the surgeons were made aware of this in their NHS practice. This was then discussed at the medical advisory committee (MAC) and the senior management meeting.
- Standard operating procedures were updated by consultants and this was disseminated to staff at staff meetings.

Pain relief

- Local anaesthetic eye drops were prescribed prior to the procedure. Patients were asked if they were in any discomfort during surgery. None of the patients we spoke with reported feeling any unnecessary discomfort.
- Patients were prescribed eye drops post treatment. We saw staff made sure patients were provided with verbal and written instructions.
- Patients were told to purchase analgesics such as paracetamol to help manage any pain.

Patient outcomes

- In the past 12 months there were no unplanned returns of a patient to theatre following surgery.
- The service provided the clinical commissioning group (CCG) with patient outcome information every month to monitor the quality of overall patient care. The data was gathered from patient satisfaction questionnaires given to each patient following treatment, and did not include any other forms of measuring outcomes, such as referral to treatment times (RTT).
- Surgery outcomes were monitored through any adverse events and the service looked for any trends in events in order to make changes to standard operating procedures.
- There was no other patient outcome audit activity in surgery. The service did not report any patient complications following surgery or treatment since the service was opened.

Competent staff

- Staff we spoke with had the correct skills and competencies to carry out the duties required of them.

- All new staff undertook an induction programme. This included a familiarisation of policies and procedures.
- The medical director had oversight of the surgeons working at the service. All of the surgeons working at the clinic also worked in the NHS in a number of local trusts including a local specialist NHS eye trust.
- There was a practising privileges policy for consultants who wished to work at the service and the ongoing requirements for those who were granted practising privileges. Practising privileges were granted by the Medical Director.
- If a surgeon wanted to join the service then this would need to be agreed with all the consultants and the chief executive of the service.
- Surgeons were required to have references from their employing NHS trust. Details of continuous professional development were required and practising privileges were reviewed every two years.
- All of the nurses were up to date with revalidation and minutes of meetings showed that revalidation had been discussed with the senior team and that support could be given to staff to complete the process. The practise manager monitored evidence of revalidation.
- We saw evidence that all staff who worked with lasers had completed core knowledge training as well as attending manufacturers training. This was refreshed every three years.
- The Laser Protection Advisor (LPA) was a certified member of the association of laser safety professionals. All staff knew who they were and had met them personally.
- Staff told us they attended an annual appraisal. We saw evidence of this in the staff records we reviewed (11 in total). All staff had attended an appraisal meeting within the last 12 months. Staff said that the appraisal process was good and that if they had concerns during the year that they could approach their manager.

Multidisciplinary working

- The service worked closely with neighbouring NHS trusts, one of which was a specialist eye hospital. The service also had been well advertised initially to local primary care services and stated they had a good working relationship with local GPs.
- The service staff, including the consultants working under practising privileges, worked well together as a team. Staff suggested there was a good relationship between medical and nursing staff, and there was a positive team ethos to deliver safe and effective patient care.
- The consultants worked well together and although they were employed under practising privileges they supported each other. They would see each other's patients and, if appropriate, cover sickness and absence.
- Staff at the service said that they had a good relationship with the community optometrists and said that they would ring up for advice if they had any problems.
- There was a strong relationship with the local CCG with regular meetings and reviews of the key performance indicators.

Access to information

- All policies, protocols, guidelines and standard operating procedures were available electronically in the service.
- Referrals, appointment letters, and clinical records were paper based. Patients' files were stored locally in locked filing cabinets.
- Consultants were required to be registered with the Information Commissioner's Office (ICO) and acted as responsible data handlers. In addition consultants ensured secretarial support staff complied with data handling guidance.
- Computers were available for staff to use and complete mandatory training.
- The service maintained open lines of communication with referring GP services. Patient records were reviewed showed regular contact with primary care services relating to referred patients, and summary information was shared with GPs following patient discharge or onward referral.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a consent policy for the service. Consent was a two stage process and consultants gained consent from patients during their outpatient appointment. When observing surgery we saw that the nurse checked consent with the patient and then the surgeon checked consent verbally with the patient before the procedure. Consent forms shared information on the benefits and potential risks of treatment.

Good

Surgery

- Consultants consented the patients for treatment and were aware of the Mental Capacity Act (2005) though the criteria for surgery would exclude some patients who did not have capacity to consent. We checked five consent forms in patients' records and all were filled in correctly.
- There was training provided on consent and the Mental Capacity Act (MCA). When we discussed MCA with staff they were aware of how this was relevant to their service.

Are surgery services caring?

Good

We rated caring as **good.**

Compassionate care

- We spoke with six patients. All patients we spoke with were happy with their treatment and their care.
- We observed staff were caring and compassionate in interactions with patients. Staff treated patients with kindness, dignity, and respect during and after surgery. Staff interacted with patients in a positive, professional, and informative manner.
- Staff escorted patients to the theatre before surgery and back to the waiting room after.
- We observed nurses introducing themselves to the patients and checking on their progress with the pre-operative eye drops.
- We observed that surgeons introduced themselves by name to the patients and engaged in conversation before taking the patients into the minor operations room.
- The service collected patient experience feedback and provided this information monthly to the CCG. From January 2017 to November 2017, 1,235 patients completed patient feedback questionnaires. Of these patients, 100% stated they would recommend the service to a friend or family member. Some specific patient feedback included: "very good service, the staff and doctor were excellent", "very friendly and relaxed atmosphere", and "the consultant explained everything to me and the treatment was second to none".

Understanding and involvement of patients and those close to them

- Staff involved patients in their care, and gave time to discuss procedures. During surgical procedures we saw informed discussions between the surgeon and patients were in-depth with discussed outcomes, expectations, risks, and recovery.
- Patients we spoke with told us they were given full explanations of the treatment, expectations and post-operative care. This was backed up by patient information leaflets and contact phone numbers.
- Family members and carers were encouraged to attend with patients and wait for them while they had their surgery.

Emotional support

- We observed a procedure in the laser treatment room and saw that the nurse who was present reassured the patient throughout the procedure. They provided support to an anxious patient and were able to allay their fears and concerns regarding treatment. They were kind, non-persuasive and made the patient feel relaxed.
- Staff supported patients during surgery if necessary by holding their hand.
- A patient fed back that, "the staff were very kind and helpful and friendly. I would recommend the clinic to everyone."

Are surgery services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- The service provided consultant led ophthalmology minor surgery and laser treatment for patients. There were 410 episodes of laser treatments and minor operations recorded at the service in the reporting period, of these 100% were NHS funded.
- Procedures were carried out every Wednesday with four procedures scheduled every session. There had been no cancelled procedures within the reporting period.
- The service was able to frequently plan the delivery of their service with the local clinical commissioning group (CCG), and could put on additional surgical sessions and clinics at short notice if needed. The service had been commissioned by the CCG to take on stable glaucoma

patients and approximately 1,000 patients were seen in the glaucoma follow-up pathway at Essex Vision since the service opened. This meant fewer patients requiring acute hospital appointments, reducing waiting times at the local NHS trusts as patients are seen in the community, and acute services more capable to focus on delivery for more complex patients.

Access and flow

- The referral to treatment times for surgical patients at the service was 100% for the reporting period (January 2017 to November 2017), this meant patients received treatment in a timely manner. Minor operations were carried out within three to four weeks after referral (total of 647 since the service opened at the time of inspection).
- Patients were referred into the service by optometrists and GPs. Following an initial assessment patients were listed for surgery. The service was adept at scheduling patients and information about the next available appointment was visible to the staff. Patients said that the service made every effort to offer them a convenient appointment.
- Patients were given staggered times to arrive for surgery and following dilation of their pupils they were taken for anaesthetic preparation and then into surgery. When a patient was being treated in theatre, another was being prepared for surgery. Processes and procedures were efficient and there was positive team working allowing effective access and flow for treatment.
- Surgery patients would be seen for one follow-up appointment and then discharged, with discharge information shared to the patients GP.
- The service did not carry out surgery on patients under the age of 18 or with significant co-morbidities or complications. This information was clearly displayed on the referral form, and patients identified with significant complications could be directly listed at the local acute trust by the service consultant.
- The service had 365 Did Not Attend (DNAs) during the reported period, representing 5% of total patient appointments. The clinical director stated the DNA rate had been high during the first few months, however they had changed the process of appointment booking to address this. The service now allowed patients to call and pick their own appointment times, and the service stopped the Friday clinic which had regularly received a high number of DNAs.

Meeting people's individual needs

- The service offered a range of patient information leaflets in communal areas and in clinic rooms. Information included specific information about the service and advisory information from charities such as the International Glaucoma Association. Leaflets were available in large print if requested, however we did not see any leaflets or signposts in languages other than English. The service used a telephone interpreting service if necessary to communicate with patients whose first language was not English.
- The service referral form required referrers to provide information on dementia or learning disability. The clinical director informed us that the service can see patients with dementia and with a learning disability, however the complexity of the patient would be assessed at triage and consultation, and if the case was too complex to manage the patient would be referred and booked to the local acute trust. The service did not monitor if staff had training in working with patients with complex needs such as dementia or a learning disability.
- The building had a separate access path to the building for patients with mobility issues, as well as elevator access to all floors. The service also provided restrooms for people with mobility difficulties.
- Following surgery patients were offered refreshments while they waited for family or carers to collect them.

Learning from complaints and concerns

- The complaints policy described the process staff should follow in the event of a patient making a complaint. Staff told us they knew how to manage a complaint and that information about complaints was shared during team meetings, which were minuted.
- We saw notices in the clinic and information in patient leaflets describing how to make a complaint. Patient information did not include information about the Optical Complaints Consumer Service.
- The practice manager told us they would attempt to resolve verbal complaints on the day, more serious complaints were escalated to the medical director. The service did not monitor any themes from these verbal or informal complaints.
- The service received no complaints during the reporting period.

Good

Surgery

Are surgery services well-led?

Good

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

Leadership / culture of service related to this core service

- The management team were visible, part of the team and took part in the day to day running of the services as well as managing the staff.
- Staff we spoke with talked positively about the medical director. They said they were supportive, approachable and managed their concerns. There was clear leadership. Staff knew their reporting responsibilities and the role they played within the service.
- Staff were complimentary about their workplace and colleagues. We did not see and were not told of any conflict within the workplace however staff told us they were confident that the manager could help to resolve conflict should it occur. Surgeons were managed by the medical director.
- There was no whistle blowing policy but staff told us they would be able to raise any concerns freely.

Vision and strategy for this core service

- The provider did not have a clearly defined vision and strategy and therefore this was not evident. Staff were not aware of the organisation's values.
- Royal College of Ophthalmology standards were incorporated throughout policies and procedures.
- The medical director told us the contract with the CCG was up for tender in April 2018 and there was a degree of uncertainty about the future of the service.

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

- There were policies to support the governance of the organisation. These key policies provided staff with clear guidelines and processes to follow. Key policies included incident reporting, information governance and medicine management.
- Medical Staff we spoke with stated they attended the Medical Advisory Committee (MAC) quarterly. This included discussion on incidents, training, professional development, and service improvement. MAC meetings included representation from other healthcare providers on site, which allowed learning discussion to be shared between services.
- The service did not have an overall risk register. However, there were risk assessments, which applied to the location, reviewed by the medical director as part of the MAC. We viewed the risks for laser risks and fire assessments. These were up to date, re-assessed, and kept for one year. As a small service, the risks to patients were low and staff were trained and skilled to manage risks at the location.
- We reviewed the surgeon's personnel file and were satisfied showed that all employment checks were complete, indemnity insurance was in place, patient feedback exercise had been completed, annual audit of performance had taken place, and appraisal meeting within the last 12 months.
- The fit and proper person's checks were adopted for the company's director, nominated individual and registered manager.

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

- There was no turnover of staff in the surgery department. Staff we spoke with enjoyed working at the service and some had worked there for many years.
- The service did not conduct staff surveys. However at regular team meetings staff were encouraged to provide feedback and suggestions to improve the service.
- All patients were encouraged to complete an anonymous satisfaction survey before leaving the clinic. The service reported the ratings as "excellent" to "very good" in over 90% of patients.

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

- The service's clinic was equipped with state of the art diagnostic and therapeutic equipment to enable a comprehensive service.
- The service had established a good reputation amongst the referrers and had seen over 17,000 patients since February 2014. In addition, the service had worked closely with a local NHS hospital and in reducing the built up workload the hospital had met their outpatient waiting period target.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as **good.**

Incidents

- There were no never events in the reporting period September 2016 to August 2017. Never events are serious incidents that are entirely preventable. Guidance or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- In the reporting period there were no incidents reported in the out-patient department. Staff we spoke with were aware of how to report an incident if they needed to. Incidents would be reported to the service manager and investigated in line with the service incidents policy.
- Incidents were discussed as part of clinical governance meetings every two months. Clinical governance meetings included representation from other healthcare providers on site, which allowed learning from incidents to be shared between services.
- Duty of candour processes were not identified in the incident policy. However, staff were aware of their responsibilities to inform patients if something went wrong during their treatment.
- 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.

Cleanliness, infection control and hygiene

- Staff informed us that nurses took responsibility for cleaning consultation rooms at the end of each clinic, and signed a record log to confirm this had been completed. We reviewed logs of cleaning rotas and found this was completed every day. Clinical areas and communal waiting areas were clean and well maintained.
- We observed positive attitudes from all staff towards hand hygiene and compliance with the service policy on "bare arms below the elbows" in clinical areas. Hand sanitising gel dispensers were visible in clinic rooms and waiting areas.
- We observed that sharps bins were available in clinical rooms and that clinical waste was disposed of appropriately. Colour coded bags for separating different types of clinical waste were in use throughout the service.
- The service had an infection control policy with sections on hand hygiene, clinical waste, blood spills, cleaning of equipment, and management of patients who may require isolation. The policy also identified the clinical director and practice manager as responsible for ensuring compliance with infection control practices.
- Mandatory training records showed that all clinical staff working for the service had completed infection control training and provided evidence to the practice manager. We observed evidence of this in 11 staff members training checklist.
- The service employed an external company to annually review infection control practices. This included an

annual visit evaluating standards of cleanliness, hand hygiene, infection control, and management of clinical waste. The most recent report, from December 2017, stated compliance with all standards of cleanliness and infection control across the service.

Environment and equipment

- Main reception area was manned during office hours and attendees were required to sign in. Patients were called by nurses for their appointments and accompanied to the treatment rooms.
- Electrical safety testing had been completed on general and specialist medical equipment used by the service. Specialist technical support was also available for laser equipment in the event of equipment not working.
- The service maintained laser equipment as part of service delivery, and the room containing equipment was locked when not in use. The local rules for laser management were visible in the clinical rooms, and the service had a laser protection advisor report completed in October 2017. The clinical director for the service was identified as the laser protection supervisor, and consultants had laser safety training. Although the laser policy was up to date, the laser protection protocols were not signed as read by consultants working with the service.
- The service maintained emergency resuscitation equipment on site. The bag was kept in a clinical room where surgical interventions were performed. The bag was checked on a weekly basis. We checked the resuscitation bag and found no security tags in place to secure the contents and protect unauthorised access to controlled medications. We found that no items were missing from the resuscitation bag.

Medicines

- The service had a policy in place for the management and administration of medication, which was regularly reviewed and in date.
- Clinical staff checked medicines refrigerator temperatures daily, and were instructed by the medication policy to report any readings outside of the recommended range. We reviewed logs of daily temperature checks and found them to be within the normal ranges.
- All medication was kept in a clinical treatment room, which was locked when not in use. Staff stated any medication supply issues were to be reported to the practice manager when identified.
- Medication stocks were checked weekly and orders were replenished when needed. Staff stated they were well supplied and had not had a case where they could not access medications, there was an arrangement with a local pharmacy to provide support at short notice if required.
- The service did not hold any controlled drugs or cytotoxic medications on site.

Records

- The service had a policy for the management of clinical records. Clinical staff were required to provide evidence of information governance training as part of their mandatory training compliance.
- Clinical records were paper based and were stored locally at on-site in locked filing cabinets in a secure room. Records were made available to the consultant before each clinic. Staff stated any elapsed records would be removed and destroyed in line with policy, however no records had elapsed.
- Secretarial staff transcribed referral, appointment, and discharge letters off-site, which were then returned and filed into folders on-site for future clinics. Consultants for the service were registered with the Information Commissioners Office (ICO) and acted as responsible staff for ensuring compliance with information governance.
- We reviewed examples of patient records and found them to be correctly filed and completed. Risk assessments were completed as part of the referral process and were evident in clinical records. Records were generally legible, identifiable, dated, and signed.
- The service carried out an annual audit of patient records to be assured notes were being appropriately completed. The most recent audit in March 2017 found that clinical records were generally well maintained and completed, with no areas of concern.

Safeguarding

- The service had a policy for safeguarding patients in place. Clinical staff were required to provide evidence of

completing safeguarding training for vulnerable adults and children as part of their mandatory training compliance (although patients under 18 were not seen clinically at the service).
- The clinical director was identified as the service safeguarding lead. Staff we spoke with were aware of who the safeguarding lead was, and stated they would be confident in raising any issues relating to safeguarding.
- There were no safeguarding concerns relating to this service reported to the Care Quality Commission (CQC) in the reporting period of September 2016 to August 2017.

Mandatory training

- For detailed findings of the section, see surgery.

Nursing staffing

- For detailed findings of the section, see surgery.

Medical staffing

- For detailed findings of the section, see surgery.

Emergency awareness and training

- For detailed findings of the section, see surgery.

Are outpatients and diagnostic imaging services effective?

We have not rated effective as we do not have enough evidence to rate this.

Evidence-based care and treatment

- For detailed findings of the section, see surgery.

Patient outcomes

- The service did not complete any national audits for patient outcomes in the outpatients department.
- The service provided the clinical commissioning group (CCG) with patient outcome information every month to monitor the quality of overall patient care. This included monitoring by activity, patient feedback, and referral to treatment (RTT). We saw evidence from minutes of meetings that commissioners visited the service and that the service was meeting their key performance indicators for initial triage for referral, time from referral to offer of first appointment, and RTT. The service stated they had not exceeded a two-week RTT since opening in January 2014, however was not collecting routine data on RTT.

Competent staff

- Staff we spoke with informed us they had an annual appraisal and had received this within the last twelve months. This was monitored by the practice manager and training records showed all clinical staff had received an appraisal within this period.
- Staff informed us they felt well supported by the management in continuing their professional development, and were given opportunities to learn and develop. All of the nursing staff had received specialist ophthalmology training.
- The practice manager ensured nurses continued to be registered with the Nursing and Midwifery Council (NMC). The Medical Advisory Committee (MAC) annually reviewed applications and continued practising privileges for consultants working with the service, as outlined in the practising privileges policy.

Multidisciplinary working

- The service did not employ any multidisciplinary staff aside from medical and nursing. Staff stated that patients requiring more complex multidisciplinary involvement in their care would be referred to the local acute trust.
- Staff we spoke with stated there was a good relationship between the nursing staff and consultants. Staff stated they worked well together as a team and felt there was a good culture within the service.
- Staff stated they had a good working relationship with the local referring GPs and optometrists, as well as the local acute trust. Staff stated they provided support and advise to referrers and had advertised their availability widely across the catchment area. The service also provided step-down outpatient appointments for stable glaucoma patients for the local acute trust, and referred more complex patients to the acute ophthalmology department.

Access to information

- We saw that there were computers for staff use, however referrals, appointment letters, and clinical records were paper based. All policies, protocols, and guidelines were available electronically.

Good

Outpatients and diagnostic imaging

- In the three month period before this inspection the service reported no instances where clinical notes were not available for outpatient appointments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had a policy for consent in place. Staff we spoke with had a good understanding of the consent process for the service and informed us that patients were routinely included in developing their assessment and treatment plans.
- We reviewed consent forms in patients' records and found that they were all signed and dated. Forms also contained information for patients on their rights in relation to consent.
- The service provided training for staff on the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). When we discussed MCA with staff they were aware of how this was relevant to their service.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

- The service collected patient experience feedback and provided this information monthly to the CCG. From January 2017 to November 2017, 1,235 patients completed patient feedback questionnaires. Of these patients, 100% stated they would recommend the service to a friend or family member. Specific patient feedback included: "very good service, the staff and doctor were excellent", "very friendly and relaxed atmosphere", and "the consultant explained everything to me and the treatment was second to none".
- We observed interactions between staff and patients and found patients were treated compassionately and with dignity. Patients we spoke with were positive about their experience of the service and felt they were treated well.
- Staff took a patient-centred approach in the interactions we observed and regularly asked the patient if they could be made more comfortable. Many patients who regularly attended for glaucoma appointments stated they were made to feel welcome as regular visitors to the service.

Understanding and involvement of patients and those close to them

- Patients we spoke with felt they were well involved and informed in their treatment and the development of their care plans, and this was reflected in patient records we viewed. Family members were involved in treatment if requested and clinical staff were patient and helpful in answering any clinical questions.
- Of 1,235 patients surveyed in the feedback questionnaire (January 2017 to November 2017), 91% rated access to information from the service as "Good", "Very Good", or "Excellent". The patient feedback questionnaire included comments that the service had changed appointments to accommodate family members attending.

Emotional support

- The service did not offer specific access to emotional support for patients. However, patients were provided with details on how to contact the service, their consultant, or an acute hospital in the event of an emergency.
- Patients who did not have family members attending could use a chaperone service, which was signposted in the main waiting area. Patients with visual impairments affecting reading could also request that letters and communications be provided in larger font sizes.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- Patients had access to a free car park as well as on road parking. The service was easily accessible by public transport and patients were informed of how best to reach the service on appointment letters.

Good

Outpatients and diagnostic imaging

- Signage at the front of the building informed patients of where they needed to go. Patients were greeted at reception by administrative staff, and were called by clinical staff when they were ready to be seen. The clinical areas did not have signage directing patients, however patients were always escorted to and from the clinic rooms.
- Glaucoma patients that were stable at the local acute trust ophthalmology department for twelve months were discharged by the service to be managed in the community here. Information on activity showed that approximately 1,000 patients were seen in the glaucoma follow-up pathway at Essex Vision. This means fewer patients requiring acute hospital appointments, reducing waiting times at the local NHS trusts, and allowing acute services to focus on delivery for more complex patients.
- The waiting area was bright and well maintained, with comfortable seating. The service had refreshment areas to make drinks and also a vending machine.

Access and flow

- There were 5,911 outpatient attendances in the reporting period January 2017 to November 2017, and of these 100% were NHS funded.
- During the reporting period of January 2017 to November 2017 the provider met the target of 100% of patients on incomplete pathways waiting 18 weeks or less from the time of referral. 100% of patients started non-admitted treatment within 18 weeks of referral in the same reporting period. Of the 5,911 patients, no patient had waited longer than two weeks for an appointment unless the patient cancelled it.
- Patients were referred through their GP or optometrist. Referral forms were triaged by a consultant, and then allocated to the most suitable consultant based on the required treatment. Patients were contacted by the service to make the booking to select an appointment of their preference. Based on triaging , the service ranked appointments by need: “Urgent”, “Soon”, or “Routine”, with “Urgent” appointments booked for the next available clinic. The service completed any diagnostic tests at the first appointment to avoid unnecessary repeat visits.
- Outpatient clinics ran Monday 9am to 7.30pm, Tuesday 5.30pm to 8pm, and Wednesday/Thursday 9am to 5pm. There were no outpatient clinics on Fridays, however the service would regularly run Saturday and Wednesday afternoon clinics to facilitate working patients.
- Surgery patients would be seen for one follow-up appointment and then discharged, with discharge information shared to the patients GP. Stable glaucoma patients where managed until they became more complex and were then transferred to the care of the local acute trust ophthalmology service.
- The service did not provide services to patients under the age of 18 or with significant co-morbidities or complications. This information was clearly displayed on the referral form, and patients identified with significant complications could be directly listed at the local acute trust by the service consultant.
- The service had 365 Did Not Attend (DNAs) during the reported period, representing 5% of total patient appointments. The clinical director stated the DNA rate had been high during the first few months, however they had changed the process of appointment booking to address this. The service now allowed patients to call and pick their own appointment times, and the service stopped the Friday clinic which had regularly received a high number of DNAs.

Meeting people’s individual needs

- The service offered a range of patient information leaflets in communal areas and in clinic rooms. Information included specific information about the service and advisory information from charities such as the International Glaucoma Association. Leaflets were available in large print if requested, however, we did not see any leaflets or signposts in languages other than English.
- The referral form required referrers to provide information on dementia or learning disability. The clinical director informed us that the service can see patients with dementia and with a learning disability, however the complexity of the patient would be assessed at triage

Learning from complaints and concerns

- For detailed findings of the section, see surgery.

Are outpatients and diagnostic imaging services well-led?

Good

Outpatients and diagnostic imaging

Good

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

Leadership and culture of service

- For detailed findings of the section, see surgery.

Vision and strategy for this core service

- For detailed findings of the section, see surgery.

Governance, risk management and quality measurement

- For detailed findings of the section, see surgery.

Public and staff engagement

- For detailed findings of the section, see surgery.

Innovation, improvement and sustainability

- Approximately 1,000 patients were seen in the service glaucoma follow-up pathway between January 2017 and November 2017 following transfer from the local acute trust. This alleviated on outpatient appointments at local hospitals, and offered patients a more accessible service in the community.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure the resuscitation bag is appropriately secured and tamper proof.
- The provider should reference duty of candour within the incident policy.
- The provider should develop a whistleblowing policy.
- The provider should ensure the laser protection protocols are signed when read by consultants working within the service.
- The service should ensure nursing staff provide evidence of up to date safeguarding training.
- The provider should consider contributing outcome data to the national ophthalmic database.
- The provider should undertake audit of surgical outcomes.
- The provider should provide information leaflets in different languages and formats.
- The provider should consider developing a corporate vision and strategy.