Operose Health (Group) UK Limited

Referral Management Centre

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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated it as requires improvement because:

- The service did not have assurances that risks within host clinics were monitored and mitigated.
- Staff did not have assurances that emergency equipment was available or safe for use in the event of a patient deteriorating.
- The service did not control infection risk well. Clinics were cluttered, cleaning schedules did not provide assurances that areas were clean, and staff were not bare below the elbows.
- We observed staff training other staff in techniques that did not follow best practice.

However:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service. 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.
- 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.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders 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. 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.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Requires Improvement	

Summary of findings

Contents

Summary of this inspection

Background to Referral Management Centre

Referral Management Centre provides eye clinic services for NHS patients across England and is run by Operose Health (Group) UK Limited. The services head office is based in Amersham, Buckinghamshire, the service had contracts with host clinics and hired out clinic rooms from 23 GP's and healthcare centres across the country.

The regulated activities provided are;

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

This was the first time the Care Quality Commission (CQC) inspected this service and was the first time the service has been rated. Not all activities carried out by Referral Management Centre are within the CQC's remit. Therefore, we have only inspected ophthalmology services.

How we carried out this inspection

We inspected four locations where regulated activities were being provided; as well as a well led inspection of the managerial team.

We spoke with 11 members of onsite staff including technicians and ophthalmologists, 13 members of staff from head office including corporate level staff and the booking team and we spoke with 16 patients.

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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that the physical environment within host clinics, including the cleanliness and facilities, are appropriate for patients to attend. Regulation 15 (1).
- The service must ensure staff have assurances that emergency equipment, including oxygen and resuscitation trolley, are available in the event of a patient deteriorating. Regulation 12 (1).
- The service must ensure risks at host clinics are managed and minimised. Regulation 17 (1).

Action the service SHOULD take to improve:

- The service should consider how they are ensured trainers have the right skills and knowledge to provide the training

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Outpatients

Safe	Requires Improvement
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Outpatients safe?

Requires Improvement

We rated it as requires improvement.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Staff explained the mandatory training they had completed. Records showed 95% of all staff had completed all of their mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff accessed their training through an online portal. When a training module had been successfully completed a message was sent to managers. Managers and staff received an email notification when training was due to expire. Staff had protected time for mandatory training. Completion of mandatory training was an agenda item on all appraisals.

New staff completed all mandatory training within the first two to four weeks of their six month probation. If a staff member did not complete all the mandatory training, the system did not allow probation to be signed off.

Although consultants working for the service also worked in the NHS and received mandatory training at their trust, managers ensured consultants also completed all in house mandatory training. This ensured staff were working to the same principles.

Clinical staff completed training on recognising and responding to patients with mental health needs. Staff received training on the Mental Capacity Act along with training in Safeguarding, Equality and Diversity, Privacy and Dignity and Chaperoning.

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. Safeguarding training levels were in accordance with job role and followed the guidance of the intercollegiate document.

Staff attended weekly meetings led by the nursing and clinical safeguarding leads. These meetings reviewed reported safeguarding incidents from across the service, discussed action points and lessons learned. The safeguarding leads also held webinars to inform staff when safeguarding legislation was updated.

Staff could give examples of how to protect patients from harassment and discrimination. Staff provided numerous examples of where they had supported a patient in a safeguarding incident, including a homeless gentleman who had been attacked and a child with no fixed address who did not attend appointments.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff at each location inspected knew the contact details of the local authority if they were required to make a referral and staff had good links with outside agencies including GP's and local safeguarding teams.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could describe the signs and symptoms of abuse, knew who the safeguarding lead was and could also describe how to make a safeguarding referral. All safeguarding concerns were reported onto the electronic reporting system and managers followed up concerns with local authorities.

All safeguarding referrals were audited to review actions taken, implementation of learning and whether processes could be improved. Staff could describe cases of learning from safeguarding referrals.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff kept equipment visibly clean, at some locations the premises were visibly dirty.

The service did not generally perform well for cleanliness. Clinical areas were generally clean, however other shared public areas were not always clean. At one site patient areas including the waiting area and toilets were visibly dirty. There was no information to confirm when the areas were last cleaned. Staff advised us this area was the responsibility of the host clinic. Clinic rooms at two sites were cluttered. Staff advised us they were only responsible for cleaning their own equipment. We did not see evidence that the rooms were cleaned prior to the clinics starting and the clutter would have made cleaning difficult.

Technicians were responsible for checking the host clinic had cleaned the clinical rooms as well as completing monthly infection prevention and control audits. Technicians had received competency training in both these areas.

Not all staff followed infection control principles including the use of personal protective equipment (PPE). Three out of 11 staff members were not bare below the elbow, which would compromise effective hand hygiene. We observed four staff members administering eye drops and one clinician did not wear gloves or disinfect their hands after treating each patient. Staff working in a non-surgical environment did not change their disposable aprons in between seeing each patient which was not in line with the providers policy. In the non-surgical environment, staff did not always follow best practice guidelines when washing their hands, despite managers telling us that staff had received theoretical and practical training in handwashing techniques. We reported this to the management team, who immediately emailed all staff reminding them of company policy. Staff were required to acknowledge that they had read the policy.

The surgeon and accompanying staff members demonstrated good hand hygiene processes when carrying out minor surgical procedures. However, they did not correctly use Aseptic Non-Touch Technique. Sterile equipment was contaminated with non sterile items in seven of the minor surgical procedures we observed. Local anaesthetic was drawn up with non-sterile gloves and placed on top of sterile surgical equipment. Non sterile forceps were also placed

on top of the sterile surgical equipment, contaminating the sterile equipment. We notified the provider of our concerns regarding Aseptic Non-Touch Technique and were assured that the staff had since completed refresher training in delivering Aseptic Non-Touch Training, and they had cancelled further minor surgical procedure clinics until training was completed.

The most recent IPC audits stated the staff were compliant in hand hygiene processes, however this did not reflect what we saw during inspection. Where areas of the audit were partially compliant, for example staff were not bare below the elbows during the audit, there was no evidence of follow up to review staff awareness. Site audits reviewed levels of PPE, liquid soap and paper towel availability. They did not reflect the physical environment where the clinics were taking place.

Staff cleaned equipment after patient contact. Staff cleaned equipment with disinfectant wipes after use. Surgical equipment was single use and disposed of correctly.

Environment and equipment

The design, maintenance and use of facilities and premises did not always keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design of the environment did not always follow national guidance. At one location a clinic room did not have appropriate sound insulation. A room was divided in half with a window, rather than a wall partition. The window was covered with a curtain; therefore people could not see into the room. However, conversations taking place in the next room were easily overheard. This was not compliant with Department of Health; Health Technical Memorandum 08-01: Acoustics 2.51 states “Private conversations should not be overheard.”

Clinical sinks at some third-party locations did not meet standards as set in the Health Building Note 00-09: Infection control in the built environment regarding dimensions, overflow and swan neck taps. Operose health policy stated “Hand washing sinks should only be used for that purpose and should be supplied with elbow/wrist operated taps, the tap should not open directly into the sink drain, nor be of a swan neck variety, there should not be an overflow in the sink nor should there be the option to use a sink plug. Hand hygiene should be taught at induction and should be audited regularly using the 5 Moments audit tools.” Therefore, the service had not assured staff were only working in environments which were compliant with their own requirements. However, two of the host clinics were due to be refurbished which would make the sinks and the design of the environment in these clinics compliant with standards.

Staff did not always carry out safety checks of specialist equipment. Company guidance stated checks should include an assessment of emergency equipment and oxygen, and they should be available on all sites. Posters directed the clinicians to where the emergency trolley, defibrillator and oxygen were stored at each location. Staff in one clinic did not have access to emergency medicines or oxygen. At the three other clinics visited, while there was emergency equipment available, there was no evidence that checks had been completed. Therefore, there was a risk that staff could not appropriately manage a medical emergency if needed.

The service had suitable equipment to help them to safely care for patients. Equipment was serviced and portable appliances all had testing labels that were in date.

Requires Improvement

Outpatients

The service was going through a process of upgrading all clinical equipment. Recent upgrades included Visual Field Analyser machines that could directly link to the services clinical system. The services rolling equipment programme was based on manufacturer life expectancy guidelines. In the two years prior to inspection all was merged onto a servicing support programme after a review noted a link between faulty equipment and cancelled clinics. Since the program was introduced the number of clinics cancelled due to faulty equipment had halved.

Staff used laptops in clinics to access systems, policies, procedures and records.

Staff at each location knew their responsibilities in the event of a fire, including; where fire exits were located, how to access fire evacuation procedures and meeting points. All new staff completed a walk-through of each host clinic to ensure they were aware of all safety measures, policies and testing practices.

Staff disposed of clinical waste safely. Clinical waste management was contracted out at all but one of the clinics, with signed agreements in place. Staff from Referral Management Centre organised collection of clinical waste at the other site where there is no contract in place for waste management.

Each location inspected had a local handbook on site, which included a crib sheet on fire evacuation procedures, location of emergency equipment and contact information for members of staff to use.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. Staff did not remove or minimise risks at host clinics. Staff did not follow guidance as stated in policy.

Staff could not always respond appropriately to any sudden deterioration in a patient's health. All of the four clinics had access to emergency equipment provided by the host, however, what was available varied and at one location, where minor surgical procedures were carried out, staff members did not know where the emergency equipment was located. We did not see any assurances that Referral Management Centre staff or the host clinic staff had checked the resuscitation trolley was up to date and ready to go in an emergency. Therefore, there was a risk equipment would fail or not be available in an emergency situation.

Resuscitation Council (UK) anaphylaxis algorithm posters were displayed in each clinic, advising the clinicians on what to do in the event of an anaphylaxis reaction. However, at one clinic, where minor surgical procedures were carried out, all four staff members were not aware if the required medications were available, and we could not find any on site. Information provided by the service demonstrated the risk of a reaction to eye drops was considered to be low and if occurred would be isolated to the eye.

Local Safety Standards for Invasive Procedures (LocSSIPs) were followed for minor surgical procedures.

The services policy stated patients should be asked about allergies at triage with this reconfirmed at the clinic. Posters at clinics prompted patients to alert a member of staff if they had any allergies, we did not observe staff directly ask patients about their allergies. While allergies were documented at triage there was a risk of a patient being placed at risk if staff were not informed of their allergies.

The service had links with local hospitals at each location in case a patient suddenly fell ill.

Staff knew about and dealt with any specific risk issues. They were trained in identifying sepsis and knew their responsibilities to immediately refer patients to a local accident and emergency department.

Requires Improvement

Outpatients

Triage was performed by ophthalmologist grade staff. They determined whether the patient was appropriate to be referred to one of the service clinics or hospital via the rapid access pathway. The booking team completed bespoke templates for each procedure to ensure all potential risks were documented and correct pathway allocated prior to the appointment. The triage staff allocated patients as either an urgent, soon or routine referral. This information was sent to the booking team who prioritised patients according to the triage recommendations. Managers monitored performance against urgent and soon cases and blocked out clinic time to ensure these key performance indicators were met.

Staffing

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

The service had enough staff to keep patients safe. Clinical staff consisted of ophthalmologists, optometrists, orthopists, diagnostic technicians and cataract nurses who worked across the 23 host clinics.

The manager could adjust staffing levels daily according to the needs of patients. The booking team arranged staffing levels based on the clinical demand. They told us that if they did not have enough clinicians then they would cancel the clinic.

Managers limited their use of bank and agency staff and requested staff familiar with the service. One ophthalmologist told us they occasionally covered a clinic if their colleagues were off sick, and they had the option to work on Saturdays if there was a demand for it.

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. Technicians immediately printed and scanned records after treatment. This ensured consultants could review reports immediately. Print outs were destroyed in confidential waste in accordance with policy and guidelines. Records were either returned to the patients GP or to the consultant for follow up using the NHS secure system. Staff could view diagnostic tests, medical history and previous notes on the system.

Records were stored securely. The services electronic record system was secure, password accessible and centrally hosted.

When patients transferred to a new team, there were no delays in staff accessing their records. Clinicians could directly message the booking team via the system if an urgent referral was needed. When patients were transferred to a new provider, the transfer of records were agreed with the commissioner and the new provider to the best method of transfer. This could be by secure nhs.net email, paper copies, encrypted memory stick or paper copies securely delivered by hand.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. The service did not have systems that safely stored medicines.

Requires Improvement

Outpatients

Staff did not always store and manage all medicines safely. Technicians did daily and weekly checks of stored medication. We found one box of medicine which was past its expiry date in one of the four clinics. Stock rotation was poor at this clinic, with items close to expiry date stored at the back of the cupboard and newer items stored at the front.

Manufacturer guidelines recommend medicines that were stored on site should be stored below 25 Degrees Celsius. There were no daily temperature checks in place. Following the inspection, the provider provided us with their Heat Wave Policy and a risk assessment to mitigate the risk of not detecting excursions in temperature. The services Heat Wave Policy stated "7. Monitor temperature – monitor the temperature of a room or area that medications are stored in, this includes emergency drugs". Contradictory to this, the risk assessment mitigated the risk of not detecting excursions in temperature by removing stock before its expiry date.

We found sharps bins with the lid open at one clinic. The opening was wide enough that a patient's hand could access sharps within, and therefore was not stored in a safe way .

Staff did not always follow systems and processes to prescribe and administer medicines safely.

Patients were often advised to buy over the counter eyedrops, however they were provided with inconsistent advice with the clinician recommending applying the drops three times a day and the technician told the same patient once a day.

Eye drop containers were destroyed in accordance to national guidelines.

Staff completed medicines records accurately and kept them up-to-date. The service used paper based prescriptions, but planed to move to electronic prescriptions in the future. The medical records were updated appropriately to reflect what was prescribed.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Managers encouraged an open reporting culture and empowered staff to report on all aspects of work, including low harm and near miss incidents and complaints, this process was supported by the use of one overarching system.

Staff received feedback from investigation of incidents, both internal and external to the service. The electronic incident system produced a daily incidents and complaints report that was reviewed by all staff. The incidents reviewed were from across the service, not just ophthalmology. Managers compiled this into a weekly summary report. They would also be discussed in clinician meetings which were held every six weeks. Feedback was given to the staff in weekly operational huddles. Lessons learnt from other areas of the service was shared with all staff members. When concerns were raised, refresher training was available when required.

Staff met to discuss the feedback and look at improvements to patient care. Staff attended an annual conference to share feedback and lessons learnt from incidents that had occurred over the previous 12 months.

Requires Improvement

Outpatients

There was evidence that changes had been made as a result of feedback from incidents. After a patient tripped on a lamp cable, a full review of the set up of all clinics was completed to assess environmental risks. Rolling seats were removed from clinics following a frail patient falling off a chair.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Front line staff managed incidents, complaints and concerns proactively. They aimed to acknowledge complaints within three days.

Are Outpatients effective?

Inspected but not rated

At present we do not rate effective for outpatient services.

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 followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were reviewed at both corporate level and locally within Referral Management Centre. Local managers reviewed policies monthly to ensure they were up to date and referenced best practice. Local managers reviewed and escalated National Institute for Health and Care Excellence (NICE) alerts down to clinicians immediately, we saw evidence these were reviewed at the clinician's team meetings.

At a corporate level, staff in the policy division of the governance team, which included subject matter experts, reviewed policies. Policies were reviewed and shared through the online reporting system.

Staff had protected time to read policies and signed to demonstrate their understanding. Policy adherence and understanding was reviewed at one to one's and appraisals.

Patient pathways and policies followed NICE guidelines. We checked seven policies and noted that all were in date, referenced appropriate legislative standards and guidelines and there was a system of reviewing including a timetable for updating policies and an allocated accountable person.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations. Managers reviewed patient outcomes as part of clinical supervision. Areas of review included; discharge communications and outcome abnormalities. Managers benchmarked the service against local hospital trusts and found outcomes were consistently better than local trusts.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers had access to a corporate audit library and schedule programme. The results from audits were analysed against and assurance framework and fed into the clinical quality assurance group for review. Weekly patient outcome audits included the floating patient report and overdue patients.

Managers and staff used the results to improve patients' outcomes. Managers introduced a new visual field program pilot study to improve efficiency. The new program demonstrated an improvement in the speed of responses and was being introduced. Managers updated the schedule to re-audit efficiency at a later date.

Managers used information from the audits to improve care and treatment. An audit of triage rejection showed 'correct' rejection of 85.8%. This was worse than the target of 93%, actions plans were in the process of being developed to improve this and a future audit was scheduled to review the effectiveness of the action plan.

Improvement is checked and monitored. Post-operative cataract care was audited and reviewed to ensure patients received positive outcomes. The most recent audit showed 97% of eyes reported achieved BCVA 6/12 or better. This refers to, if a person has a visual acuity of 6/12, they can see detail from 6 metres (20 ft) away the same as a person with "normal" eyesight would see it from 12 metres (39 ft) away.

Competent staff

Managers appraised staff's work performance and held supervision and appraisal meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff attended annual clinical training days that were in addition to their mandatory training. These days were used to ensure staff were using up to date techniques and best practice and included reviews of audits and glaucoma referrals. Managers reviewed annual practising privileges where consultants completed competency checks and evidenced, they were insured.

Managers gave all new staff a full induction tailored to their role before they started work. New starters received a six-month probationary period that included a corporate induction and a two-week operational induction. Induction plans were job specific and ensured new staff completed all mandatory training prior to working operationally.

Managers supported staff to develop. In the 12 months prior to inspection, 94% of staff had received an appraisal and 100% of staff had received a clinical supervision.

The clinical educators supported the learning and development needs of staff. The training and resilience technician supported the upskilling of staff. Technicians were in the process of going through an upskilling programme to develop the role. Increased responsibilities included completing measuring visual acuity, intraocular pressure tests and optical coherence tomography (OCT) tests. OCT is a non-invasive imaging test that uses light waves to take cross-section pictures of your retina.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings were regularly held, and meeting minutes were made available for all staff to access if they were unable to attend.

Managers identified poor staff performance promptly and supported staff to improve. Staff had access to the performance management policy and knew their responsibilities regarding performance. Managers rated one to one assessments using a red, amber, green rating system and showed us action plans for staff members who fell into amber or red categories.

Requires Improvement

Outpatients

Managers used recruitment systems that ensured staff were qualified, fit to work and staff files met legislative standards. Recruitment systems did not include any personal information to reduce the chances of discrimination within recruitment processes.

We observed a technician receiving training in minor surgical procedures, where techniques for Aseptic Non-Touch Techniques were not demonstrated correctly. The trainer informed us that their last training was in 2007, and they had not received any refresher training since this date. Managers were not assured the staff providing the training were qualified. We notified the provider of our concerns were assured the trainer and all staff had since completed refresher training and cancelled further Minor Operations clinics until training was refreshed. The lead diagnostic technicians, who carry out the training programme, were also booked to attend an Ophthalmology training refresher course by an external accredited provider and were enrolled on an accredited Health Education England Approved NHS train the trainer course.

Multidisciplinary working

Staff 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. Managers held regular meetings and and we saw evidence of discussions with clinical commissioning groups, local authorities, GP's, Integrated Care Systems, local hospitals and host clinics to manage patient care and review performance.

The service used the same communication system as the NHS, therefore information was securely sent to relevant teams, for example clinical commissioning groups, host clinics and GP's.

Seven-day services

Key services were available to support timely patient care.

Clinics were available across the country, opening times were variable in accordance with patient demand, including being open at weekends. Typical opening times were 8:30am until 5:30pm. Weekend clinics were also available, and children's clinics ran until 7pm.

Staff could call for support from doctors and other disciplines. Staff could contact the clinical director immediately if they had a question, concern or wanted a second opinion regarding a patient's results.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. At all locations inspected, healthy living information leaflets were available. For example, we saw leaflets detailing how a healthy diet can improve eyesight and particular foods and food groups that are beneficial.

Staff advised patients on recommended vitamins and minerals that would holt or reduce the impact of Age-Related Eye Diseases.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. Staff discussed how genetics and racial factors increased the risk of cataracts and glaucoma and arranged follow up appointments accordingly.

Requires Improvement

Outpatients

Consent and Mental Capacity Act

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 or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff completed training for the Mental Capacity Act as part of their mandatory training programme. At the time of inspection 100% of staff had completed training within the previous 12 months.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consent for all surgical procedures, for example cataract surgery, required verbal consent at the time of booking and written consent before the procedure could take place, which was in accordance with legislation. Consent for some treatments, for example glaucoma clinics, required verbal consent as they were non-invasive. Staff ensured consent was recorded and in line with legislative standards.

Staff clearly recorded consent in the patients' records. All records we checked where written consent was required were clearly documented. Staff checked a tick box on the electronic record to demonstrate verbal consent had been obtained.

Staff could describe and knew how to access policy on Mental Capacity Act. Staff we spoke with knew their responsibilities regarding implementing the Mental Capacity Act and staff showed us how to access policies on their system.

The service displayed posters describing the five principles of the Mental Capacity Act as a reminder to staff. These were presumed capacity, supporting decision making, unwise decisions, best interests and less restrictive options.

Are Outpatients caring?

Good

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 staff being calm, kind and compassionate with patients.

Patients said staff treated them well and with kindness. One patient thanked the technician for adding a note to records to clarify the pronunciation of her name. Staff advised us "We try to treat patients like a member of the family" and "We treat patients as we wish to be treated".

Staff provided examples of where they demonstrated compassionate care. At one clinic, staff remained onsite three hours after a clinic closed to support a patient who had fallen ill. The booking team provided numerous examples of where they had expedited an appointment for a patient who was on a hospital waiting list but was very anxious

regarding the length of time they would have to wait to be seen. Managers arranged for a patient to be accepted for an appointment at a host clinic where the contract had already ended. This was after the patient was concerned about their treatment and the length of time it would take to be seen at the newly appointed service. We observed a clinician giving a patient's carer advice on correct administration of eyedrops as the patient was forgetting to do them themselves, causing high pressure to develop within the eyes. The clinician arranged to review the patient to see if the help given from the carer would remedy the high pressure and avoid the need for further, more invasive treatment.

We reviewed 46 compliments from the services most recent compliment report, themes included the speed of the service and the compassionate care displayed by staff. Patient feedback was reviewed quarterly at governance meetings.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff referred patients to GP's and third-party counselling services when extra support was required.

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. The booking team extended appointment times when patients presented at booking as being anxious. Repeat patients who historically required more time, were also given an extended appointment to enable staff to have more detailed conversations and allay fears and concerns.

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. Staff confirmed with patients the reasoning for the appointment, what the appointment would consist of, next steps and gave patients numerous opportunities to ask questions. Staff also provided patients with information sheets and a telephone number if they later thought of any further questions or concerns.

Staff talked with patients, families and carers in a way they could understand. Staff used photos and diagrams to explain diagnosis and treatment. We saw staff using a photo of a tear duct and gland to explain a dry eye diagnosis.

Patients gave positive feedback about the service. Patients we spoke with said that "Staff here are lovely", "They're all very nice" and "The service is always very good".

Are Outpatients responsive?

Good

We rated it as good.

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.

Requires Improvement

Outpatients

Managers planned and organised services so they met the changing needs of the local population. The service operated out of 23 clinics across the country to provide a range of locations where patients could be treated.

Staff in the booking team sent patients information packs that included details of the planned procedure, a feedback form and details of the clinic where the treatment was going to take place, including a map and information regarding parking and transportation. Staff in the booking team asked patients if they wished to have a chaperone at the time of booking. Posters at clinics advertised chaperones and staff worked together to ensure a member of the team was always available if a patient required a chaperone. Criteria for host clinics included parking availability and wheelchair access.

Meeting people's individual needs

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

Staff supported patients living with dementia and learning disabilities. The booking system included a dementia and learning disability flag. This reminded staff to check the status of patients booking in and allocate a double appointment slot for patients who required extra support, for example, patients over 90 years old.

The service had information leaflets available in languages spoken by the patients and local community. Information leaflets were available in the most common languages spoken in each local area. At two clinic we saw leaflets available in eleven local languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff in the booking team assessed the need for an interpreter, including British Sign Language, during the booking process. If an interpreter was required, the booking team extended the length of the appointment and sent a task to the technician two days before the appointment to book the interpreter. At one clinic we saw a technician was sent a task to book an interpreter and the appointment was extended.

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 better than national standards.

The service received referrals from either GP's or opticians as an unassigned referral. The system passed on the referral to the booking team who ensured all documentation had been received. Referrals were received via the NHS electronic referral system, email, fax or a specialist eye referral system.

Staff monitored patient's statuses throughout the admission, treatment and discharge process. Staff showed us the booking system, each patient was allocated a colour depending on where they were in the pathway. The system did not allow staff to proceed in the process until certain criteria had been completed. For example, a patient could not be discharged from the system unless a GP letter was completed.

The system ensured patient follow up appointments were not lost as they remained on the patient listing until the booking team arranged another appointment. The system would not allow any progression of the patient, until another appointment was made. We saw staff change the colour status of no-show appointments and saw the booking team pick these up and arrange another appointment in the future.

Requires Improvement

Outpatients

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Managers advised us that "Embargoed appointments enable the service to see urgent and soon cases faster than the national average". The national average waiting list at the time of inspection was two weeks for urgent cases compared with the two-day target being met by the service. Patients classed as 'soon' appointments were seen within two weeks, and all patients were seen within four weeks, the national average was 18 weeks.

Learning from complaints and concerns

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

Patients knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern. Patients we spoke with knew how to make a complaint and advised us they were given a feedback form as part of the booking process. The services website clearly displayed various methods for logging a complaint either in writing or via telephone or email.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to access the complaints policy as well as their responsibility in reporting complaints to managers.

Managers investigated complaints and identified themes. At corporate level the governance team reviewed complaints daily and allocated a risk score to each complaint to ensure appropriate review. There was a monthly executive review of all complaints from across the business to identify themes.

Managers at Referral Management Centre reviewed all complaints daily via the electronic reporting system which sent an automatic notification when a complaint was logged. The system included a dashboard that had an automated escalation matrix that prioritised complaints and identified themes. The clinical governance team reviewed all complaints daily, the registered manager monitored action plans and patient responses and shared learning with staff at team meetings. We viewed three complaints and noted responses and timelines were in accordance with policy.

Are Outpatients well-led?

Requires Improvement

We rated it as requires improvement.

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.

The managerial team were supported by Operose Health to develop their skills and ensure they had the abilities to run the service. For example, all managers received monthly one to one's with the corporate lead executives. The head of quality assurance was being supported to complete a clinical auditing master's degree.

An independent review of the service demonstrated it would benefit from recruiting clinical leads. This led to the service recruiting a lead nurse and a dedicated lead optometrist had already been recruited.

Staff were very complimentary of the leadership team. Especially the registered manager, stating they always had time to speak with staff if they had any concerns or questions and staff felt listened to and respected.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Managers recently relaunched the services values and behaviours which included a prescribed set of expectations. Staff were involved in developing and creating these values. Managers discussed values and behaviours at appraisals and said they were "Working hard to embed them into front line teams" from the executive team down.

The main strategy at the time of inspection was to expand the ophthalmology service. Managers understood the importance of host clinic contract retention to support this. There were several internal transformation programmes running, designed to support the expansion of ophthalmology. The digital transformation programme included refreshing systems, introducing e-prescribing and text correspondence and expanding online presence. The clinical transformation programme included introducing remote consultations, laser treatments and upskilling technicians, which was in progress.

Culture

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

Staff could contact the services Freedom to Speak Up Guardian if they needed support. Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken. Staff knew who their representative was and said they felt confident in going to them if they had a concern. The Freedom to Speak Up Guardian received a slot at monthly team meetings to provide any updates and promote an open culture.

The chief executive officer sent blogs to all staff. These reflected on activities that demonstrated the corporate values and was also an opportunity to celebrate success as staff nominated colleagues for Heroes and Team Awards.

Staff could access an employee assistance programme; mental health of staff was important to leadership team. Staff advised us they appreciated the '11 o'clock stop' programme where staff had 10 minutes extra down time a day. All staff we spoke with advised us they "Really enjoy working here".

In response to a staff survey and a focus on wellbeing, the service moved to be a national living wage employer and was in the process of reviewing staff benefits.

Staff could nominate colleagues for an internal quarterly hero award. This was created to recognise staff who went above and beyond. Staff we spoke with advised they appreciated the recognition from the management team.

Requires Improvement

Outpatients

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

There were clear governance structures that showed accountabilities and responsibilities both within Referral Management Centre and Operose Health.

At a corporate level, the service was managed by a board of directors. The board formally met once a month and had weekly informal meetings up to 3 times a week. The assurance structure was headed by the integrated governance committee assurance forum. There were two divisional level boards and below the top-level boards, there were sub-groups for; commercial, finance, clinic viability, waiting list management and key performance indicators.

Staff attended monthly meetings to review changes to policies and practices and discussed the potential purchases and training required for new equipment. The service was in the process of introducing electronic prescribing. Staff also attended a daily huddle that was used as an opportunity to discuss overtime and to review timekeeping.

There was a weekly clinic viability meeting. Clinician and technician team meetings and huddles were held 3 times a week and the monthly quality assurance and operations management group fed into the clinical and operations meeting, which was held fortnightly. The clinical quality, workforce, information governance and finance group met quarterly and these fed into the integrated governance committee. Reports from the integrated governance committee, clinical and operations meetings and the ISO steering group were all fed to the executive board. These meetings had clear frames of reference and responsibilities and ensured all areas of the service were reviewed.

We had identified numerous concerns regarding patient safety, which had not been recognised through the providers governance processes.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. Managers did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.

The service had two levels of risk management, one corporate and a divisional risk register for services. Corporate risks were reviewed quarterly at corporate assurance forums as well as board level. Agenda items for assurance forums included clinical quality, information governance, workforce and finance.

The divisional risk register was divided into clinical and non-clinical risks. All risks were allocated a risk score based on likelihood and impact as well as a list of controls to reduce the risk rating and action plans to remove the risk. Managers reviewed the register at monthly leadership meetings and quarterly at assurance boards. Risks on the register included impact of COVID-19, recruitment and talent retention.

There were site specific risk registers for the initial three months of the mobilization of a service. These were reviewed at monthly clinical mobilization meetings. After the three-month period there were no site-specific risk registers, after this time staff logged concerns on the incident and reporting system and managers reviewed risks during local audit.

Managers completed a site review before signing a host clinic contract at a particular location. The review included checking, the suitability of rooms and whether the site was fit for purpose. This did not reflect the risks we saw. one clinic did not provide suitable rooms, and another was visibly dirty. There was a risk that managers were not aware of risks at host clinics, and therefore, would not act.

Requires Improvement

Outpatients

The service used a quality improvement tool kit, which created a rolling internal inspection programme to ensure compliance. This included site visits; however, the programme did not pick up on the risks identified during inspection.

Information Management

Staff could find data they needed, in easily accessible formats to understand performance. The information systems were integrated and secure.

Staff advised us data systems were easy to follow and demonstrated how they found information regarding performance and improvements, for example incidents.

The service used the same communication system and records as the NHS, meaning staff transferred information and reports using an integrated system.

All systems were password protected as we saw staff lock computers when they left their post to protect information and keep it secure. There had been no data protection breaches in the previous 12 months. Staff completed data protection training as part of their health and safety mandatory training.

As part of the strategy, the service was increasing its digital presence, including introducing the NHS app and providing a new short message service text system.

Engagement

Leaders actively and openly engaged with patients and staff to plan and manage services.

Technicians and consultants attended a bi-weekly catch up where learning from incidents, complaints, complements and concerns were discussed.

Managers and staff communicated via an electronic communication app to provide updates and as a method for staff to communicate with each other. There were several channels including 'our family', 'managers channel', 'news channel', and a 'CQC channel'. Managers advised us it was a place to share information, praise staff and promote an open-door policy.

Patients received feedback forms as part of their booking information pack. Consultants received these responses every three months and learning, and reflection was a part of the appraisal process. Managers advised us the service was looking at developing digitised patient feedback in the future.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

To support the development of the service and recognise the decline in numbers of ophthalmologists. Managers developed the use of clinical optometrists, as optometrists' numbers were not in decline. Managers created a successful recruitment programme and advised us optometrists sought to work for the service.

The service was registered to provide bespoke training as it was accredited to develop its own training programmes. For example, the service created the level 3 safeguarding training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not have assurances that emergency equipment, including oxygen and resuscitation trolley, were available in the event of a patient deteriorating.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Managers must ensure risks at host clinics are managed and minimised.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Managers did not ensure that the physical environment within host clinics, including the cleanliness and facilities, were appropriate for patients to attend.