City Hospitals Sunderland NHS Foundation Trust

Sunderland Eye Infirmary

Quality Report

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Date of inspection visit: 16 and 19 September 2014
Date of publication: 20/01/2015

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Good
Surgery	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Sunderland Eye Infirmary is one of two acute hospitals forming City Hospitals Sunderland NHS Foundation Trust.

The trust provides acute hospital services to a population of around 350,000 people across the Tyne and Wear and Durham area. In total the trust has 855 beds across two hospitals and employs around 4,923 staff. Sunderland Eye Infirmary has 22 beds.

Sunderland Eye Infirmary provides ophthalmology care and treatment in surgical, accident and emergency (A&E) and outpatient services for people living in the Tyne, Wear and Durham area.

We inspected Sunderland Eye Infirmary as part of the comprehensive inspection of City Hospitals Sunderland NHS Foundation Trust, which includes this hospital and Sunderland Royal Hospital. We inspected Sunderland Eye Infirmary on 16 and 19 September 2014.

We carried out this comprehensive inspection because the Care Quality Commission (CQC) had placed City Hospitals Sunderland NHS Foundation Trust in risk band 2 in the CQC Intelligent Monitoring system.

Overall, we rated Sunderland Eye Infirmary as good. We rated it as good for being safe, effective, caring, responsive and well-led across each of the acute services they provide within the hospital.

Our key findings were as follows:

- Processes were in place to implement and monitor the use of evidence-based guidelines and standards to meet patients' care needs.
- Patients were provided with care in a compassionate manner and treated with dignity and respect.
- Arrangements were in place to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. All areas we visited were clean. Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile) rates were within an acceptable range for the size of the trust.
- Patients were able to access suitable nutrition and hydration, including special diets. Patients reported that, on the whole, they were content with the quality and quantity of food.
- We had no concerns about staffing at this hospital. Staffing establishments and skill mix were maintained and regularly reviewed to maintain optimum staffing levels.
- We had no concerns about mortality rates at this hospital.
- The importance of patients' and public views were recognised and mechanisms were in place to hear and act on patients' feedback.

We saw an area of outstanding practice:

- The enhanced recovery pathway for cataract surgery and the role of the primary nurse were viewed as an excellent development of the service and resulted in individual surgeons' cataract audits showing consistently higher visual acuity outcomes compared to benchmark standards (UK Cataract National Dataset audit).

However, we found that there was an area of poor practice that was a trust-wide issue resulting in a compliance action at trust level. This is reported in the trust provider report, which states:

The trust must:

- Ensure that patient group directions (PGDs), which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment, are updated and monitored in line with trust policy

The trust should:

Summary of findings

- Review the storage of medical records within this hospital.
- Develop mechanisms for reviewing and if necessary updating patient information, particularly in the outpatient department.
- Introduce patient surveys specific to the outpatient department.
- Review the participation in audits, including clinical audits in the A&E department.
- Review the arrangements for the role of the Eye Infirmary when dealing with major incident/events across the trust.
- Review the practice of recording patient concerns in the electronic nursing evaluation, in line with best practice guidance.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	We rated accident and emergency (A&E) as good. Systems were in place to ensure that incidents were investigated and lessons learned. There were enough staff to meet the needs of patients. Sufficient numbers of staff received mandatory training. There were effective arrangements in place for the prevention and control of infection and areas observed were visibly clean. However, we found that patient group directions (PGDs) were out of date. The chief pharmacist told us that this was flagged up on the risk register in January 2014 and should be resolved by December 2014. The department used evidence-based guidelines in the management of eye emergencies. However, although clinical audits were carried out in the Sunderland Eye Infirmary (Eye Infirmary), there was little evidence of clinical audits being undertaken in the A&E department. We found that staff received appraisals and were supported in their development. There was evidence of multidisciplinary team working with other departments and specialities in the Eye Infirmary, and with the main A&E department at Sunderland Royal Hospital. Patients were provided with care in a compassionate manner and were given emotional support. The department met the four-hour wait standard and did not breach the ambulance trolley wait standard. Access to translation and sign language interpretation services was provided. However, we were told that relatives sometimes translated clinical consultations with patients, at their request, which is not good practice. We were also told that when concerns were raised, these were entered into the patients' electronic nursing evaluation. We found that staff had a vision of the Eye Infirmary as a centre of excellence that they were proud of. There was a system of clinical and managerial leadership for the directorate of ophthalmology, in which A&E sits. We found that following a review of inappropriate referrals and misdiagnoses, a greater level of clinical leadership had been introduced into the department.

Summary of findings

Surgery

Good

Effective arrangements were in place for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance, and staff were encouraged to report incidents and lessons learnt from these were shared.
Staffing establishments and skill mix were regularly reviewed to maintain optimum staffing levels. Effective handovers took place between staff shift and included daily safety briefings to ensure continuity and safety of care.
Effective arrangements were in place to prevent and control infection and manage medicines.
Processes were in place to implement and monitor the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes.
Processes were in place to identify the learning needs of staff and opportunities for professional development.
The enhanced recovery pathway for cataract surgery and the role of the primary nurse were viewed as excellent developments of the service and resulted in consistently higher visual acuity outcomes compared with benchmark standards.
Patients spoke positively about staff, particularly the kind and caring interactions on the wards and between staff and patients.
Systems were in place to plan and deliver services to meet the needs of local people. Services were available to support patients, particularly those who lacked capacity to access the services they needed.
The trust's vision, values and strategy had been cascaded to wards and departments, and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities, and ward leadership was good.
The service recognised the importance of the views of patients and of the public, and mechanisms were in place to hear and act on patients' feedback.

Outpatients and diagnostic imaging

Good

Overall, we rated outpatient services as good. Care and treatment received by patients in the Eye Infirmary outpatient department was effective, caring, responsive and well-led. Patients were happy with the care they received and found it to be caring and compassionate. However, some improvements were required with

Summary of findings

safety. Improvements were needed with the storage of medical records, and ensuring that patient group directions (PGDs) are updated and monitored appropriately.

Staff were well trained and supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm because policies were in place to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them.

Some patient information leaflets in the department were past their review dates.

On the whole, the services offered were delivered in an innovative way to respond to patients' needs and ensure that the department worked effectively and efficiently. For example, a third pre-clinic room was opened to help ease bottlenecks and improve the flow of patients.

Good

Sunderland Eye Infirmary

Detailed findings

Services we looked at
Urgent and emergency services; Surgery; Outpatients and diagnostic imaging

Contents

Detailed findings

Background to Sunderland Eye Infirmary

Sunderland Eye Infirmary is one of two acute hospitals forming City Hospitals Sunderland NHS Foundation Trust. City Hospitals Sunderland was established as an NHS trust in April 1994. Under the Health and Social Care (Community Health and Standards) Act 2003 the trust became an NHS foundation trust in July 2004. The trust provides acute hospital services to a population of around 350,000 people across the Tyne and Wear and Durham area. In total, the trust has 855 beds across two hospitals and employs around 4,923 staff. Sunderland Eye Infirmary has 22 beds.

We carried out this comprehensive inspection because the Care Quality Commission (CQC) placed City Hospitals Sunderland NHS Foundation Trust in risk band 2 in the CQC Intelligent Monitoring system.

Sunderland Eye Infirmary provides ophthalmology care and treatment in surgical, accident and emergency (A&E) and outpatient services for people living in the Tyne and Wear and Durham area.

The eye infirmary provides: a cataract treatment centre with a purpose-built twin theatre suite, providing day case surgery; an inpatient ward (Haygarth Ward) with separate areas for male and female patients and a dedicated children's ward; and outpatient ophthalmology services in neighbouring hospitals and community facilities.

Additionally, the Eye Infirmary provides a seven-day ophthalmic accident and emergency (A&E) unit serving the north east. The A&E unit treats approximately 30,000 patients per year, who present with conditions ranging from minor irritations to major ocular trauma. Further outpatient clinics are held at South Tyneside, Durham and Hartlepool.

Ophthalmic outpatient clinics are held in several different areas on the site, each with a separate reception and waiting area.

Our inspection team

Our inspection team was led by:

Chair: Doctor J Ahluwalia, Medical Director

Head of Hospital Inspections: Julie Walton, CQC

The team included CQC inspectors and a variety of specialists: consultant in emergency medicine, consultant paediatrician, consultant clinical oncologist, consultant obstetrician and gynaecologist, consultant anaesthetist, consultant in palliative medicine, surgical registrar, ophthalmic registrar, junior doctor, clinical nurse specialist, senior nurses, emergency nurse practitioner, student nurses and experts by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- A&E
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatient services

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to

share what they knew about the hospital. These organisations included the clinical commissioning group, local area team, Monitor, Health Education England and Healthwatch.

We carried out announced visits on 16 and 19 September 2014. During the visits we held a focus group with a range of hospital staff including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including from the wards, theatres, critical care, outpatients, maternity and A&E departments. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We held a listening event on 16 September 2014 in Sunderland to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

Facts and data about Sunderland Eye Infirmary

Sunderland Eye Infirmary provides ophthalmology care and treatment in surgical, A&E and outpatient services for people living in the Tyne and Wear and Durham area.

Last year (during the 12 months from the week of 21 January 2013), 31,880 patients attended the A&E department at Sunderland Eye Infirmary. In August 2014, 2,734 patients attended the A&E department.

Over 8,000 patients are admitted to or undergo surgery at Sunderland Eye Infirmary each year.

Between April 2013 and March 2014, 95,623 patients attended the outpatient department. The ratio of new appointments to reviews was 1:4.

Sunderland is the 44th most deprived area in England out of 326 local authorities. Local health profiles show that, in a number of areas, the health of people in Sunderland is significantly worse than expected, with all children's and young peoples' health being significantly worse than expected.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Not rated	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both A&E and outpatients.

Urgent and emergency services

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The accident and emergency (A&E) department of the Sunderland Eye Infirmary is part of City Hospitals Sunderland NHS Foundation Trust. It provides emergency ophthalmic service for north east England. Last year (during the 12 months from the week of 21 January 2013), 31,880 patients attended the A&E department. In August 2014, 2,734 patients attended the department.

We followed the journey of two patients and spoke with six members of staff. We observed care being undertaken and viewed the clinical records of patients on the department's electronic patient record system. We also inspected the environment and amenities.

Summary of findings

Systems were in place to ensure that incidents were investigated and lessons learned. Sufficient numbers of staff received mandatory training. However, we found that patient group directions (PGDs) were out of date, which could create a risk of patients receiving the incorrect medicine. The chief pharmacist told us that this was flagged up on the risk register in January 2014 and should be resolved by December 2014.

The department used evidence-based guidelines in the management of eye emergencies. However, although clinical audits were carried out in the Eye Infirmary, there was little evidence of clinical audits being undertaken in the A&E department.

We found that staff received appraisals and were supported in their development. There was evidence of multidisciplinary team working with other departments and specialities in the Eye Infirmary, and with the main A&E department at Sunderland Royal Hospital.

Patients were provided with care in a compassionate manner, and were given emotional support.

The department met the four-hour wait standard and did not breach the ambulance trolley wait standard.

Access to translation and sign language interpretation services were provided. However, we were told that relatives sometimes translated clinical consultations

Urgent and emergency services

with patients, at their request, which was not good practice. We were also told that when concerns were raised, this was entered in patients' electronic nursing evaluations.

We found that staff had a vision of the eye infirmary as a centre of excellence that they were proud of. There was a system of clinical and managerial leadership for the directorate of ophthalmology, in which A&E sits. We found that following a review of inappropriate referrals and misdiagnoses, a greater level of clinical leadership had been introduced into the department.

Are urgent and emergency services safe?

Good

Systems were in place to investigate incidents and for the learning from these incidents to be discussed at clinical governance and team meetings.

We found the department to be visibly clean, and audits were undertaken of compliance with infection control standards. The environment and facilities were suitable for the care and treatment being undertaken in the department.

An electronic patient record system allowed staff to enter patients' details directly into the database. Patients were assessed on arrival and a triage system used (a system to ensure patients were assessed who needed priority care); systems were in place to respond to patient risk. Enough staff were available to meet the needs of the service. Staff received mandatory training, including in safeguarding procedures.

We found that PGDs were out of date, which could create a risk of patients receiving the wrong medicine. The chief pharmacist told us that this was flagged up on the risk register in January 2014 and should be resolved by December 2014.

Incidents

- The Strategic Executive Information System (STEIS) showed that no serious incidents relating to the A&E department occurred in the last year.
- The trust's incident report log showed that 10 incidents with a rating of no harm or minor harm occurred in A&E between June and August 2014.
- The trust investigated serious incidents using root cause analysis. (There had been no recent serious incidents.)
- We spoke with the charge nurse responsible for the A&E department, who told us that no serious incidents had occurred over the last year.
- The charge nurse explained the process involved in the investigation of incidents through a description of how a recent drugs' error had been investigated. In this particular case the wrong percentage of eye drops had been administered to a patient. This had resulted in an investigation which had led to remedial action,

following which the lessons learned had been communicated to staff. The process had been overseen by the directorate of ophthalmology's clinical governance group.
- We reviewed the minutes of the September 2014 meeting of the clinical governance group, which discussed outstanding incidents and showed how learning was shared.

Cleanliness, infection control and hygiene

- The environment and facilities were visibly clean.
- We saw staff wash their hands and use hand gel between patients, and 'bare below the elbows' policies were adhered to.
- We observed a cleaner working in the department throughout the time we were there, who adhered to trust policy and procedures.
- Hand hygiene dispensers were located throughout the department, which we observed staff using.
- The minutes of the September 2014 meeting of the directorate of ophthalmology's clinical governance group discussed the findings of an infection control audit. This audit found 100% compliance with infection control.

Environment and equipment

- A waiting room led to a large triage area and smaller consulting and treatment rooms.
- The reception area in the waiting room was very close to the seating area, which could make it difficult for patients to have a confidential conversation. However, we could not assess this on the day of the inspection, because very few people were in the waiting room.
- Although there was no designated waiting room for children, a waiting room was available in the adjacent orthoptic department, which mainly dealt with children. This waiting room had toys and was a more suitable environment for children than the main waiting room.
- There was a resuscitation trolley with a defibrillator. We found that this had been checked on a regular basis.

Medicines

- The ophthalmic nurse practitioners prescribed and some also administered medicines based on PGDs. We spoke with the ophthalmic nurse consultant in the department, who was responsible for updating the PGDs.
- On reviewing the PGDs, we found that some were out of date. The chief pharmacist told us that this was flagged up on the risk register in January 2014 and should be resolved by December 2014.

Records

- An electronic patient record system had recently been introduced into the department. Although this system was compatible with that used at the A&E department at Sunderland Royal Hospital, it was not compatible with the electronic patient record system used by local GPs.
- There was however a system for sending out letters to GPs following patient discharge. We reviewed one of these and found that it contained all relevant information.
- We observed staff completing the electronic patient record. There was also a system for using paper records if there was a failure of the electronic system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed an ophthalmic nurse practitioner examining a patient. During this process, the ophthalmic nurse practitioner gave a full explanation of what was involved, in order to obtain the patient's consent.
- Trust training records showed that 100% of nursing staff in the directorate of ophthalmology had undertaken training in consent.
- The charge nurse said that staff had access to training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Safeguarding

- Data on training was provided for the directorate of ophthalmology, which incorporated the Eye Infirmary A&E department.
- The trust training records showed that 80% of medical staff and 81% of nursing staff had completed Level 2 training in child protection. This was in line with the trust standard that 80% of all staff should undertake this training.
- The training records also showed that 91% of nursing staff had undertaken adult safeguarding training at Level 1, and 73% of medical staff had also completed the training. This was in line with the trust standard that 80% of all staff should undertake this training.

Urgent and emergency services

- The charge nurse for A&E informed us that since April 2014, nursing staff had started Level 3 training in child protection. This training was ongoing.

Mandatory training

- The charge nurse told us that staff used an electronic staff record to book themselves onto mandatory training courses.
- The charge nurse had access to the electronic record and was able to check the numbers of staff attending courses. Attendance was around 90%.
- Data provided by the trust showed that 80 to 100% of medical and nursing staff in the directorate of ophthalmology, the level at which the trust recorded this information, had received mandatory training.
- Of the nursing and medical staff, 96% had undertaken training in resuscitation and infection control.

Assessing and responding to patient risk

- When patients arrived, a qualified ophthalmic nurse used a triage system. Treatment was then undertaken by ophthalmic medical staff or an ophthalmic nurse practitioner.
- The department used an electronic tracker to record where each patient was in their journey through the department.
- There were clinical guidelines based on specialist best practice and National Institute for Health and Care Excellence (NICE) guidelines.
- We found there was an algorithm which measured patients' clinical acuity and could be updated on the electronic database. This measured patients from category three – a lower category of risk for patients with chronic ophthalmic conditions – through to category one for patients with sight-threatening disease or major trauma to the eye.

Nursing staffing

- During the day, the department was staffed by three ophthalmic specialist nurses.
- At weekends the department was staffed by two ophthalmic nurses.
- At night, one ophthalmic nurse practitioner was present.
- We were informed that all shifts were staffed by an ophthalmic nurse practitioner.
- During the day, as well as there being a charge nurse managing the department, a nurse consultant was on duty. The nurse consultant was responsible for supporting the nurse practitioners as well as providing care and treatment to patients.
- At night, the nurse on duty in A&E was also the site manager for the Eye Infirmary. As such, this person led the cardiac arrest team that responded to emergencies in the hospital. To undertake this role, the nurse was qualified up to the level of intermediate life support.
- The trust informed us that the directorate of ophthalmology had not used an acuity tool to assess staffing levels in the A&E department as an ophthalmology specific acuity tool was unavailable nationally. However, the charge nurse told us that there were enough staff to provide a safe service for patients and to develop staff.

Medical staffing

- Consultant cover was provided by an on-call rota of consultants. These on-call arrangements were shared with the general services of the Eye Infirmary.
- This cover took the form of a general ophthalmologist supported by a specialist registrar, as well as by another consultant responsible for vitreo-retinal conditions. (These conditions affect the back of the eye.)
- For three days a week between 9am and 12.30pm, an ophthalmic consultant was based in the department. The matron told us that the trust intended to increase this cover in the department to five days a week.
- The most senior doctor in the department was a specialist registrar. (Specialist registrars are doctors undertaking higher specialist training.)
- Specialist registrars provided support to junior medical trainees working in the department.
- All the trainees were undertaking specialist training in ophthalmology.
- A junior trainee told us that the senior on-call cover arrangements were very good.

Major incident awareness and training

- The senior nurse told us that the Eye Infirmary accepted eye emergencies during major incidents following triage at Sunderland Royal hospital. This senior nurse had not been involved in any major incident exercises organised by the trust.

Urgent and emergency services

- We spoke with an A&E consultant at the Sunderland Royal location, who told us that the ophthalmic A&E department had not been involved in any of the Sunderland Royal recent exercises.
- We reviewed the action cards for the trust's major incident plan, and none were related to ophthalmic medical or nursing staff.
- The senior nurse was aware of the local area and the risks of major incidents involving ophthalmic injuries. This nurse told us that risks had decreased since improvements in industrial health and safety; however, chemical plants in Teeside provided an area of risk for major ophthalmic trauma.
- The senior nurse told us that 20% of their attendances resulted from ophthalmic trauma.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

The department used evidence-based guidelines in the management of eye emergencies. However, although clinical audits were carried out in the eye infirmary, there was little evidence of clinical audits being undertaken in the A&E department.

We found that staff received appraisals and were supported in their development. There was evidence of multidisciplinary team working with other departments and specialities in the Eye Infirmary, and with the main A&E department at Sunderland Royal Hospital.

Evidence-based care and treatment

- The department used guidelines, based on evidence-based practice, for the management of eye emergencies.
- There were also algorithms for the treatment of specific conditions such as acute angle glaucoma.
- New guidelines for procedures were discussed at meetings of the directorate of the ophthalmology clinical governance group.

Pain relief

- Pain relief medication was available in the A&E department. However, because the department deals with ophthalmic conditions, no opiate analgesia was used in the department.
- There was no evidence of any recent audit of pain medication. Ophthalmic A&E departments were not examined as part of the College of Emergency Medicine pain audits.

Patient outcomes

- Ophthalmic A&E departments were not examined as part of the College of Emergency Medicine audits.
- The September 2014 meeting of the directorate of ophthalmology's clinical governance group reviewed recent audit presentations. These had included a presentation of an audit of Deprivation of Liberty Safeguards, by a consultant in elderly medicine.
- We reviewed an audit of medication undertaken in September 2014. It checked whether the details of the medicines used had been properly recorded and whether the medicines had been properly used. The audit covered 70 patients treated by the nurse practitioners. The results showed 100% compliance.

Competent staff

- We spoke with a member of the nursing staff, who felt supported to undertake training.
- The majority of the nursing staff were ophthalmic nurse practitioners, and were supported to obtain their professional qualifications.
- There was yearly appraisal and also clinical supervision when requested or when thought necessary in the interests of people's personal development.
- New starters received more regular supervision as part of their induction into the department.
- A junior doctor told us that the system of supervision was good.
- Data provided by the trust showed that rates of appraisal for nursing staff in the directorate of ophthalmology, the level at which A&E staff were recorded, was at 70% for the financial year 2013/14. In the period between April 2014 and July 2014, it was 60%. In both these periods, for medical staff the rate stood at 100%.

Multidisciplinary working

Urgent and emergency services

- Because of the specialist nature of the Eye Infirmary, the A&E department worked closely with other departments in the hospital. Consultant cover was provided on a rotational basis by ophthalmic consultants in the trust.
- We reviewed the orientation manual for new practitioners at the Sunderland Royal Hospital A&E department. It explained that if a patient had a facial injury with eye involvement, the Sunderland Royal Hospital A&E department sought advice from the A&E department at the Eye Infirmary.

Are urgent and emergency services caring?

Good

Patients were provided with care in a compassionate manner, and were given emotional support. We also observed staff behaving towards patients in an understanding manner.

Compassionate care

- The results of Friends and Family tests were examined in the trust's July 2014 A&E performance and quality report. It stated that the results showed satisfaction scores greater than those at other A&E departments. It was unclear whether this was comparing an ophthalmic A&E department with a general A&E department. However, it was comparable with A&E at Sunderland Royal Hospital.
- While following the journey of two patients through the department we observed staff treating the patients in a compassionate manner.

Patient understanding and involvement

- We followed two patient journeys through the department. We found that at all stages the clinical staff gave patients full explanations of the treatment they intended to provide.
- One patient told us they had been advised to attend by their optician. This person said they did not have to wait very long before being seen.
- After the initial triage system had been used, patients had to wait before treatment. Such patients told us they had been informed of the reason why they had to go back to the waiting room.
- The patients we spoke with were happy with the service they received.

Emotional support

- We observed a patient receiving care from a member of the nursing staff. The nurse made sure the patient was comfortable and provided reassurance throughout the process.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Good

The A&E department met the four-hour wait standard and did not breach the ambulance trolley wait standard.

Access to translation and to sign language interpretation services was provided. However, we were told that relatives sometimes translated clinical consultations with patients, at their request, which was not good practice.

We were also told that when concerns were made, this was entered into the patient's electronic nursing evaluation.

Service planning and delivery to meet the needs of local people

- The A&E department provided a specialist emergency ophthalmic service to people living in north east England.
- The charge nurse for A&E told us that other specialist ophthalmic hospitals and units visited to look at the work of the A&E department.
- The charge nurse for A&E said that no work had been undertaken to benchmark the department against other similar ophthalmic A&E departments. This was because there were very few such services in the country.
- In the year up to September 2014, the average re-attendance rate was 7.17%. (This is the percentage of patients who came to the department more than once during this period.)

Access and flow

Urgent and emergency services

- In the last two years the ophthalmic A&E department has met the standard for 95% of patients to be admitted, transferred or discharged from A&E within four hours.
- The week before the inspection (the week ending 14 September 2014), 99.02% of patients were admitted, transferred or discharged from A&E within four hours, which met the standard.
- A floor nurse manages the four-hour wait and prevents any breaches of the standard.
- There were few ambulance attendances at this hospital, so there were no concerns with achieving the 15-minute ambulance handover standard.

Meeting people's individual needs

- Access to translation services for people whose first language is not English was provided.
- People who were profoundly deaf and used sign language had access to sign language interpretation services.
- We were told that instead of obtaining professional translation and interpretation services, the department sometimes used patients' relatives, at their request, which is not best practice.

Learning from complaints and concerns

- The charge nurse told us that most complaints were verbal. We were told that staff would complete an incident form and make an entry in the patient's notes. However, it is not considered good practice to record concern details in patients' electronic nursing evaluation; good practice is to enter details into a complaints database.
- The trust's complaints database showed that between April 2013 and August 2014 the trust received four complaints concerning the ophthalmic A&E department.
- Complaints and any lessons learned were an agenda item at meetings of the directorate of ophthalmology's clinical governance group, which A&E managers attended.
- Information about the patient advice liaison service (PALS) was available throughout the department.

Are urgent and emergency services well-led?

Good

There was a system of clinical and managerial leadership for the directorate of ophthalmology, in which A&E sits. We found that following a review of inappropriate referrals and misdiagnoses, a greater level of clinical leadership had been introduced into the department.

We found that staff had a vision of the eye infirmary as a centre of excellence that they were proud of.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation, with clear aims and objectives. The trust's values and objectives had been cascaded across the department and were visible in all areas.
- Staff had a clear understanding of the trust's values and were able to repeat the vision and discuss its meaning with us during individual conversations.
- We spoke with the charge nurse responsible for managing the department who was able to give a full explanation of the vision of the Eye Infirmary as a sub-regional centre of excellence.

Governance, risk management and quality measurement

- The directorate of ophthalmology clinical governance group met monthly.
- Complaints, incidents, audits and quality improvement were discussed in this forum.
- Feedback from these meetings was given at department meetings.
- Risk registers were in place for this service. These had controls and assurance in place to mitigate risk. There were regularly reviewed.

Leadership of service

- The senior leadership of the department was provided by a triumvirate consisting of a clinical director, a business manager and a matron.
- Senior nursing staff had bi-annual meetings with the trust's Chief Executive. They would report back from these meetings to other staff.
- The charge nurse for A&E said that band six nursing staff and above had the opportunity to meet the Chief Executive twice a year.

Urgent and emergency services

Culture within the service

- Staff we spoke with felt they were well supported by their senior managers, and thought the Eye Infirmary was a “lovely place to work”.
- Staff were proud of the work they did and felt they offered a safe service to patients.

Public and staff engagement

- A&E is a small department, and we observed good communication between staff.
- There was no evidence of engagement with the local population who use the service.

Innovation, improvement and sustainability

- A report in the Eye Infirmary risk register for October 2010 stated that there had been an increase in the number of inappropriate referrals and misdiagnoses. This was seen to have resulted from a lack of consultant input. This led to consultants being based in the department three days a week, from 9am to 12.30pm, with an intention to increase this to five days a week.

Surgery

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

Information about the service

Sunderland Eye Infirmary provides a range of ophthalmic services for the population of Sunderland and the immediate surrounding area, and is also a sub-regional centre serving the north east of England.

The Eye Infirmary provides the following:

- A cataract treatment centre with a purpose-built twin theatre suite, providing day case surgery
- An inpatient ward (Haygarth Ward) with separate areas for male and female patients and a dedicated children's ward

Over 8,000 patients are admitted to or undergo surgery at Sunderland Eye Infirmary each year.

During this inspection we visited the Haygarth Ward and clinic and all theatres on site. We spoke with 29 patients and relatives and 14 members of staff. We observed care being given and surgical procedures being undertaken. We observed care and treatment and looked at care records for eight people. We also viewed performance information for the Sunderland Eye Infirmary.

The Sunderland Eye Infirmary provides ophthalmic services for children on a day case and outpatient basis. Service provision for children is integrated with and managed by the adult service.

The Haygarth Ward has a designated four-bed bay for the care of children and one adolescent room which was opened during daytime hours only for three to four operating sessions per week. This area also has its own play area and toilet/bathroom facilities. The service provides treatment for squint surgery and other common elective eye surgery for children. Emergencies admitted may include examination under anaesthesia, foreign bodies in the eye and lacerations to the cornea, etc.

The hospital employed two registered children's nurses who also worked on the adult ward when no children had been admitted. The ward had suitable equipment and support to care for a child undergoing surgery, including a separate paediatric resuscitation trolley.

Surgery

Summary of findings

Effective arrangements were in place for reporting patient and staff incidents and allegations of abuse which was in line with national guidance and staff were encouraged to report incidents. Lessons from any learning were shared. Staffing establishments and skill mix were regularly reviewed to maintain optimum staffing levels and effective handovers took place between staff shift and included daily safety briefings to ensure continuity and safety of care.

Arrangements were in place to effectively prevent and control infection and manage medicines.

Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes.

Processes were in place to identify the learning needs of staff and opportunities for professional development.

The enhanced recovery pathway for cataract surgery and the role of the primary nurse were viewed as excellent developments of the service and resulted in consistently higher visual acuity outcomes compared with benchmark standards.

Patients spoke positively about staff, particularly about the kind and caring interactions on the wards and between staff and patients.

Systems were in place to plan and deliver services to meet the needs of local people. Services were available to support patients, particularly those who lacked capacity to access the services they needed.

The trust's vision, values and strategy had been cascaded to wards and departments, and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities and ward leadership was good.

The service recognised the importance of the views of patients and the public, and mechanisms were in place to hear and act on patient feedback.

Are surgery services safe?

Good

Effective arrangements were in place for reporting incidents relating to patients and staff and allegations of abuse, which was in line with national guidance. Staff were encouraged to report incidents, and most received feedback on what had happened as a result. Lessons from any incidents were shared with staff.

Staffing establishments and the skill mix were regularly reviewed to maintain optimum staffing levels at all times of day and night. Effective handovers took place between staff shifts and included daily safety briefings to ensure continuity and safety of care.

Arrangements were in place to effectively prevent and control infection and manage medicines. Anaesthetic equipment was checked daily. Care records were completed accurately and clearly.

Incidents

- Staff were aware of the process for investigating when things had gone wrong. Staff were encouraged to report incidents and were aware how to do so. Feedback was given to ward managers, who confirmed that themes from incidents were discussed at staff meetings and displayed in staff rooms.
- Staff were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic system (Ullyses), and were encouraged to do so.
- There had been no Never Events reported at this hospital. One serious incident relating to surgery had occurred; this had been fully investigated by the trust, which had identified the root causes of the error and actions needed to stop a reoccurrence. These actions included changes to current procedures, lessons learnt disseminated throughout the surgical division and increased vigilance with WHO checklist requirements.
- The reporting of patient safety incidents was in line with that expected for the size of the hospital.
- Incidents were discussed at ward meetings and meetings of clinic managers from across the trust, which promoted shared learning.

Safety thermometer

Surgery

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Ophthalmology is exempt from the Safety Thermometer but patient safety information was clearly displayed on boards on Haygarth Ward and unit.
- The patient safety information showed that the service was providing 100% 'harm free' care.
- Risk assessments were being appropriately completed on admission.

Cleanliness, infection control and hygiene

- All patient areas were visibly clean. We saw staff wash their hands and use hand gel between patients, and 'bare below the elbows' policies were adhered to.
- Infection control information was visible in all ward and patient areas; the ward had an infection prevention and control information board. This showed 100% compliance with both hand hygiene and dress code audits.
- All elective patients undergoing ophthalmic surgery were screened for methicillin-resistant Staphylococcus Aureus (MRSA). Policies were in place to isolate patients, when appropriate, in accordance with infection control policies.
- The surgical ward at this hospital had reported no cases of MRSA or Clostridium difficile (C. difficile).
- Clinical waste bins were covered with foot opening controls. The appropriate signage was used for the disposal of clinical waste.
- In Haygarth Ward and unit, separate hand-washing basins, hand wash and sanitisers were available.
- Records of a recent environmental audit showed that the service was 100% compliant with infection control procedures.
- Nursing staff had received training in Aseptic Non Touch Techniques. This encompassed the necessary control measures to prevent infections being introduced to susceptible surgical wounds during clinical practice.
- Data showed a low rate of post-cataract surgery Endophthalmitis for 2013 (0.071%). This was an increase on the previous year (0.028%), although this remained low.
- Audits recognised that the incidence of cases of Endophthalmitis post intravitreal injection remained low but analysed causes and identified actions to reduce incidences further.
- Infection control audits were completed every month and monitored compliance with key trust policies such as hand hygiene.
- We saw extensive communication between the primary nurse and consultant during surgery.
- Pre-assessment of patients was in accordance with British Association of Day Surgery guidelines.
- The children's play area was clean and tidy, and contained a lot of toys. We saw the cleaning schedule for toys and the audits for checking the mattresses and for other cleanliness checks.

Environment and equipment

- We observed that checks for emergency equipment, including equipment used for resuscitation, were carried out daily.
- Paediatric resuscitation equipment was situated on a standard trolley and was checked weekly or when needed. We saw standard equipment including paediatric airway management equipment, appropriate medication and a defibrillator shared with adults.
- This equipment had been used once in the past six years. Staff were able to discuss how a resuscitation event would be handled.
- Records showed that the trust's maintenance team serviced equipment under a planned preventive maintenance schedule.
- All freestanding equipment in theatres was covered and dated when cleaned. Equipment was appropriately checked and cleaned regularly. Adequate equipment was available in the ward to ensure safe care.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- The preparation and administration of controlled drugs was subject to a second independent check. After administration of an individual preparation, the stock balance was confirmed to be correct and the balance recorded.
- A supply of medication was available in a locked cupboard in the children's area, comprising basic analgesics, local anaesthetic and eye drops.

Records

- Nursing documentation was kept at the end of the bed and centrally within the ward, and was completed appropriately.
- Care pathways were in use, for example, for cataract removal.
- Haygarth Ward completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. Electronic and paper records we looked at were completed accurately.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely in line with Data Protection Act principles to ensure that patient confidentiality was maintained.
- Children's records included a pre-assessment, medical notes, consent forms (written in detail and signed and dated), completed pre-operative checklist, anaesthetic record, medication administration record (MAR) chart, discharge checklist, and discharge letter and prescription.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and saw that consent had been obtained appropriately for all patients; this was in line with the trust's policy and Department of Health guidelines.
- Staff told us that the consultant responsible for the patients' care undertook mental capacity assessments, and Deprivation of Liberty Safeguards were referred to the trust's safeguarding team.

Safeguarding

- Staff were aware of the safeguarding policies and procedures and had received training in this area. They were also aware of the trust's whistleblowing procedures and the action to take.
- Compliance with adult and children's safeguarding Level 1 training was 100% across all surgical areas. All appropriate staff had children's safeguarding Level 3 training.

Mandatory training

- The performance report for the division of surgery at Sunderland Eye Infirmary showed that staff were up to date with their mandatory training. For example, 100% of staff had attended consent training, 92% had attended infection prevention and control training, and 84% had attended resuscitation training during 2013 and 2014. These figures were against a trust attendance target of 80%.
- Staff we spoke with confirmed that they were up to date with mandatory training, and this included attending annual cardiac and pulmonary resuscitation training.

Assessing and responding to patient risk

- The Haygarth Ward used the National Early Warning Score (NEWS) system, a recognised early warning tool for the management of deteriorating patients.
- Clear directions for escalation were printed on the observation charts, and staff we spoke to were aware of the appropriate action to take if patients scored higher than expected.
- We looked at completed charts and saw that staff had escalated correctly, and that repeat observations were taken within the necessary time frames.
- We observed that theatre staff practised the 'five steps to safer surgery' of the World Health Organization (WHO). Audits showed 100% compliance between May 2014 and August 2014.

Nursing staffing

- Nurse practitioners managed the ophthalmic ward at Sunderland Eye Infirmary.
- Staffing levels for wards were calculated using a recognised tool. The trust had recently undertaken work to reassess the staffing levels on wards. This was to ensure that staffing establishments reflected the acuity of patients.
- There was a safe staffing and escalation protocol to follow if staffing levels for a shift fell below the agreed roster.
- Nurse staffing levels on Haygarth Ward and within theatres were compliant with the required establishment and skill mix.
- The average 'fill rates' both for nurse and care staff between May 2014 and July 2014 showed an average of 100%.
- Two qualified members of staff were on duty at all times during the day, and one qualified member of staff was on duty overnight on Haygarth Ward.

Surgery

- Limited use was made of bank or agency staff. Staff told us they were asked to cover staff shortages at the Sunderland Eye Infirmary. The trust's use of bank and agency staff was 1.3% during 2014, against an England average of 6.1%.
- Two children's nurses were employed as part of the ward staff, managed by the ward manager. They told us they felt well supported by ward staff and the trust safeguarding team.
- When there were no children at all on the ward, the children's nurses worked in the adult area or, occasionally, on children's wards at the main hospital to maintain general children's skills.

Surgical staffing

- Surgical consultants from all specialities were on call for a 24-hour period.
- There were a number of vacancies in anaesthetic junior rotas due to a national reduction in the number of trainee posts.
- Two ophthalmologists undertook children's surgery, and a paediatric anaesthetist from the main trust site was used on the children's list. Regular children's sessions were held Monday, Wednesday and Thursday mornings and Tuesday afternoons.
- Average inpatient attendances were between two and 14 children per week. Surgical lists had no more than four children, and often fewer.

Major incident awareness and training

- Business continuity plans for surgery were in place. These included the risks specific to the clinical areas and the actions and resources required to support recovery.
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience and response.
- The trust's major incident plan provided guidance on actions to undertake for departments and staff who may be called on to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency.

Are surgery services effective?

Good

Processes were in place to implement and monitor the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. Mortality indicators were within expected ranges.

Processes were in place to identify the learning needs of staff and opportunities for professional development. Effective communication and collaboration took place between multidisciplinary teams who met regularly to identify patients requiring visits or to discuss any changes to the care of patients.

The enhanced recovery pathway for cataract surgery and the role of the primary nurse were viewed as excellent developments of the service and resulted in individual surgeon's cataract audits showing consistently higher visual acuity outcomes compared with benchmark standards (UK Cataract National Dataset audit).

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute for Health and Care Excellence (NICE), the Association of Anaesthetists of Great Britain and Ireland, and the Royal College of Surgeons.
- Enhanced recovery pathways were used for patients, and seen to be particularly effective in cataract surgery. The role of the primary nurse had been introduced to provide a nurse to escort the patient through the care pathway and follow up each cataract patient, ensuring continuing care.
- Individual surgeons' cataract audits showed consistently higher visual acuity outcomes compared with benchmark standards (Cataract National Data Set and the National Ophthalmology Database).
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments, and these were in line with best practice.

Surgery

- The surgery departments took part in all the national clinical audits that they were eligible for. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- We looked at examples of local audits relating to infection control, checking of controlled drugs and use of personal protective clothing in theatres and recovery; these showed 100% compliance.

Pain relief

- Planned pain relief was administered for ophthalmic patients who were on the enhanced recovery pathway.
- Patients were regularly asked about their pain levels, particularly immediately after surgery; details were recorded on a pain scoring tool that was used to assess patients' pain levels. All patients reported that their pain management needs had been met.

Nutrition and hydration

- Patients were screened using the Malnutrition Universal Screening Tool (MUST). Where necessary, patients at risk of malnutrition were referred to the dietician.
- Records showed that patients were advised of the time that they would need to fast from. Fasting times varied depending on whether the surgery was in the morning or afternoon.
- Patient-led assessments of the care environment (PLACE) scored the Haygarth Ward at 98% for food during August 2014.

Patient outcomes

- There were no current Care Quality Commission (CQC) mortality outliers relevant to surgery at Sunderland Eye Infirmary. This indicated that no more deaths than expected had occurred among patients undergoing surgery at this hospital.
- The percentage of ophthalmology surgery performed as day case surgery was above the national expectation (92%). (The British Association of Day Surgery recommends that 90% of certain surgeries are completed as day cases.)
- Re-admission rates for patients at Sunderland Eye Infirmary were 0.3% between July 2013 and June 2014.
- The hospital participated in the Cataract National Data Set and the National Ophthalmology Database. Audits showed that patients exceeded outcomes for refraction within one dioptre of planned (Royal College of Ophthalmology standard), outcomes better than the British Oculoplastic Surgery Society and the retinal reattachment primary success rates.

Competent staff

- We were told by staff and observed from the training matrix that appraisals were undertaken annually. Records for 2014 showed that 88% of staff in surgery had received an appraisal.
- Staff could request informal one-to-one meetings. Monthly staff meetings took place.
- Most junior doctors told us they attended teaching sessions and participated in clinical audits. They told us they had good ward-based teaching, were well supported by the ward team and could approach their seniors if they had concerns.
- The General Medical Council (GMC) national training survey 2013 identified no risks in these areas and all outcomes were within expectations.
- Revalidation and clinician outcomes were assessed and monitored by the Deanery.
- The nurses who looked after children admitted to the ward were trained in paediatric intermediate life support.
- Nursing staff had undertaken further development to enable them to take on additional roles such as nurse injectors.

Multidisciplinary working

- Therapists worked closely with the nursing teams on the ward where appropriate. Daily handovers were carried out with members of the multidisciplinary team.
- Input from the pharmacy was available on the ward during weekdays.
- Staff explained that the ward worked with local authority services as part of discharge planning.

Seven-day services

- Consultants were available on call out of hours and would attend when required to see patients at weekends.
- Daily ward rounds were arranged for all patients. New patients were seen at weekends when necessary.
- Access to diagnostic services – for example, X-rays – was available seven days a week.
- An on-call pharmacist was available out of hours. Pharmacy staff were available on site during the week.

Surgery

Are surgery services caring?

Good

We observed positive, kind and caring interactions on the wards and between staff and patients. Patients spoke positively about the standard of care they received.

Patients we spoke with felt they understood their care options and were given enough information about their condition. Services were provided to ensure that patients received appropriate emotional support.

Compassionate care

- Throughout our inspection at this hospital we observed patients being treated with compassion, dignity and respect. We saw that patients were spoken to and listened to promptly; patients told us that staff had "been very good", "reassuring" and "answered questions well".
- Staff were very attentive to the comfort needs of patients. Patients we spoke with were positive about the care and treatment they had received.
- All the patients we spoke with commented on the dedication and professionalism of staff and the high quality of care and treatment received. We spoke with nine patients; they told us that their care was, "spot on", "wonderful", "fantastic, relaxed" and that, "This is a lovely place; treated in a caring way."
- Patients were complimentary about the staff in the service, and felt informed about and involved in decisions concerning their care and treatment. We observed patients being kept informed throughout their time within the anaesthetic room and theatres.
- We saw doctors introduce themselves appropriately. Curtains were drawn to maintain patients' dignity.
- The hospital's response rate for the Friends and Family test was lower than the England average between June 2013 and June 2014, but scores were consistently higher across all areas than the England average during that period.

Patient understanding and involvement

- Patients and relatives felt involved in the patient's care and had been given the opportunity to speak with the consultant looking after the patient.
- The ward manager was available on the ward, so that relatives and patients could discuss any issues.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- All the patients we spoke to had been made fully aware of the surgery that they were going to have; this had been explained to them.

Emotional support

- Patients felt able to talk to ward staff about any concerns – either about their care or in general. Patients did not raise any concerns during our inspection.
- Information was included within care plans to highlight whether people had emotional or mental health problems.
- Patients were able to access counselling services, psychologists and the mental health team.
- Assessments for anxiety and depression were done at the pre-assessment stage. Nursing staff provided extra emotional support for patients both pre- and post-operatively.

Are surgery services responsive?

Good

Systems were in place to plan and deliver services to meet the needs of local people. Staff were responsive to people's individual needs. Identified issues relating to waiting times were continuously monitored, and waiting list initiatives were implemented to meet demand.

Services were available to support patients, particularly those who lacked capacity to access the services they need. Information about the trust's complaints procedure was available for patients and their relatives. There was evidence that the service reviewed complaints and acted on information about the quality of care.

Service planning and delivery to meet the needs of local people

- The hospital had an escalation and surge policy and procedure to deal with busy times.
- Meetings were held to monitor the availability of beds in the hospital; staff reviewed data on planned patient discharge to assess future availability of beds.

Surgery

- When patient numbers and demand were high, elective patients were reviewed and placed in an order of priority for cancellation to prevent urgent patients, including cancer patients, being cancelled.

Access and flow

- A pre-assessment meeting was held with each patient before the surgery date. Any issues concerning discharge planning or other patient needs were discussed at this stage.
- The pre-assessment was completed for children before surgery, and they were taken to the children's area playroom so that they could see the beds.
- The consultant visits children before and after surgery and undertakes their discharge, although there is nurse-led discharge for some surgery. Discharge planning for children was begun before admission.
- Patients requiring assistance from social services upon discharge from the surgical day ward and Haygarth Ward were identified at pre-assessment, and plans were continuously reviewed during the discharge planning process.
- The average length of stay was below the England average for both elective (zero days) and non-elective (one day) patients.
- Patients who had had their operations cancelled were treated within 28 days of cancellation.
- Enhanced recovery pathways were used for patients; this was seen to be particularly effective in cataract surgery. The primary nurse facilitated the progress of patients through their treatment.
- The role of the primary nurse had been introduced to provide a nurse to escort patients through the care pathway and follow up on each cataract patient. Patients were accompanied throughout their journey within the hospital from admission through anaesthesia, the procedure and discharge.
- The role of the primary nurse was supported by an eye clinic liaison officer employed by the trust and shared with a neighbouring NHS trust.

Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. All wards had dementia champions as well as a learning disability liaison nurse who could provide advice and support with caring for people with these needs.
- Suitable information leaflets were available in a pictorial and easy-read format and described what to expect when undergoing surgery and post-operative care.
- The ward had access to an interpreter as required. Requests for interpreter services were identified at the pre-assessment meeting.
- Access was provided to an independent mental capacity advocate when best-interest decision meetings were required.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. No complaints had been received in theatres at this hospital within the last nine years.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager.
- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service and the mechanisms for making a formal complaint. We saw leaflets available throughout the hospital informing patients and relatives about the complaints process.
- Complaints were handled in line with trust policy. Information was given to patients about how to make a comment, compliment or complaint. Processes were in place for dealing with complaints at ward level and through the trust's Patient Advice and Liaison Service.
- Complaints and concerns were discussed at monthly staff meetings, where associated training needs and learning were identified as appropriate.
- For patients or their relatives who might need help or assistance with making a complaint, contact details for the Independent Complaints Advocacy Services (ICAS) were visible in the ward and throughout the hospital.

Are surgery services well-led?

Good

The trust's vision, values and strategy had been cascaded to wards and departments, and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities, and ward leadership was good. Staff felt supported and had seen positive changes to improve patient care.

Surgery

The service recognised the importance of patient and public views, and mechanisms were in place to hear and act on patient feedback. Staff were encouraged and knew how to identify risks and suggest improvements.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation, with clear aims and objectives. The trust's values and objectives had been cascaded across the surgical ward and were visible in ward areas.
- Staff had a clear understanding of the trust's values and were able to repeat the vision and discuss its meaning with us at focus groups and during individual conversations.

Governance, risk management and quality measurement

- Clinical governance meetings were held once each month. The minutes of the meetings showed that complaints, incidents, audits and quality improvement projects were discussed and action taken where required, including giving feedback to staff about their individual practice.
- We saw that action plans for Never Events were monitored across the division, and subgroups were tasked with implementing elements of the action plan where appropriate.

Leadership of service

- Staff told us that leadership of the service was good. They said staff morale was good and they felt supported at ward level.
- Each of the surgical specialities had a clinical lead; there was also a divisional lead.
- Staff spoke positively about the service they provided for patients. They emphasised that quality and patient experience are a priority and everyone's responsibility.
- Nursing staff stated that they were well supported by their managers, although we were told that one-to-one meetings and appraisals were irregular.
- Medical staff stated that they were supported by their consultants and confirmed that they received feedback from governance and action planning meetings.

Culture within the service

- Staff worked well together and there was respect not only between the specialities but across disciplines. We saw good team working on the ward between staff of different disciplines and grades.
- Staff were well engaged with the rest of the hospital and reported an open and transparent culture on Haygarth Ward. They reported good engagement at ward level and felt they were able to raise concerns and these would be acted on.
- Staff spoke positively about the service they provided for patients. High quality compassionate patient care was seen as a priority.

Public and staff engagement

- The Friends and Family Test showed that 100% of patients attending Sunderland Eye Infirmary were extremely likely or likely to recommend the service to their family and friends.

Innovation, improvement and sustainability

- Systems were in place to enable learning and improve performance, which included the collection of national data, audits, and learning from incidents, complaints and accidents.
- Evidence showed that staff were encouraged to focus on improvement and learning. We saw examples of innovation, such as the development of the primary nurse role and specific care pathways.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Sunderland Eye infirmary outpatient department is set within the Sunderland Eye Infirmary site. Between April 2013 and March 2014, 95,623 patients attended this outpatient department. The ratio of new appointments to reviews was 1:4.

Ophthalmic outpatient clinics are held in several different areas on the site, each with a separate reception and waiting area. We visited all outpatient areas as part of this inspection.

During the inspection we spoke with 33 patients, three department managers, one nurse, three doctors, two relatives, three healthcare assistants and 10 support and administrative staff. We observed the outpatient environment, checked equipment and looked at patient information.

Summary of findings

Overall, the care and treatment received by patients in the Eye Infirmary outpatient department was effective, caring, responsive and well-led. Patients were happy with the care they received and found staff to be caring and compassionate.

Staff were well trained and supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm, because policies were in place to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them.

There were some areas needing improvement, such as the storage of medical records and ensuring that patient group directions (PGDs) were updated and monitored appropriately. Some patient information leaflets in the department were past their review dates. Also, there was no evidence of patients completing satisfaction surveys specifically in relation to outpatient services.

On the whole, the services offered were delivered in an innovative way to respond to patients' needs and ensure that the department worked effectively and efficiently.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

Incidents were reported and investigated, and lessons learned. The cleanliness and hygiene in the department was within acceptable standards, and sufficient personal protective equipment was available to protect patients and staff from cross-infection and cross-contamination. Sufficient clean and well maintained equipment was provided to ensure that patients received the treatment they needed in a safe way.

Staff were aware of the various policies in place to protect children and vulnerable adults or those with additional support needs. Patients were asked for their consent before care and treatment was given. The department had sufficient well trained nursing and medical staff to ensure that patients were treated safely. Staff also demonstrated that they were aware of their responsibilities in the light of major incidents.

Patients were, on the whole, protected from receiving unsafe care, because medical records were available for outpatient clinics with only a very few exceptions.

The storage of medical records was not ideal, because staff had to go outside the building, sometimes at night, to locate records. There was a risk that this could have an impact on the safety and wellbeing of staff. The trust was aware of this and appropriate risk assessments had been completed.

PGDs, which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment, were not updated and monitored in line with trust policy. The chief pharmacist told us that this was flagged up on the risk register in January 2014 and should be resolved by December 2014.

Incidents

- The trust had reported six serious incidents within the outpatient departments last year.
- The trust used an electronic system to record incidents and near misses. All staff who work in the department were able to access the system to record incidents.
- We spoke with five staff about the incident reporting system. All but one member of staff knew how to access the system and report incidents.
- Staff were able to give examples of incidents that had occurred, investigations into incidents and changes in practice that had resulted from the investigations.
- The department had robust systems in place to report and learn from incidents, to reduce the risk of harm to patients.

Cleanliness, infection control and hygiene

- We saw that, and patients reported that, staff washed their hands regularly before attending to each patient.
- Personal protective equipment such as vinyl and latex gloves, protective eye glasses and aprons was readily available to staff. Once used, these were disposed of safely and appropriately.
- The outpatient areas and clinic rooms were visibly clean and tidy. We saw staff maintaining the hygiene of the areas using appropriate wipes to clean equipment between use by patients, thus reducing the risk of cross-infection or cross-contamination between patients.
- Hand gel was available in treatment rooms for staff and patients, and in most toilets for the use of patients and visitors.
- Staff in the outpatient department took part in regular hand-washing audits. The frequency had recently been reduced from monthly to quarterly, due to the good results obtained by the outpatient department. We saw the latest certificate, which showed 100% compliance.

Environment and equipment

- The environments of the outpatient department were well lit and airy.
- During our inspection, there was sufficient seating for patients in the waiting areas.
- Some areas of the department, such as the pre-appointment preparation rooms, were cramped, and some rooms were divided in half using only temporary partitions or curtains. This meant that in some areas it was not possible to maintain patient privacy. Other rooms were difficult to negotiate with a wheelchair.

Outpatients and diagnostic imaging

- Overall, the outpatient department was not big enough to meet the needs of all patients. The trust had acknowledged this, and work was underway to address the issue. A team of staff were discussing whether the site could be expanded.
- Within the outpatient department we saw sufficient equipment to meet the needs of patients and the department. Staff told us that there was enough equipment to meet patients' needs.
- Equipment was cleaned regularly and serviced in line with the manufacturers' guidance. Staff showed us how they cleaned equipment. The equipment we looked at was clean. Maintenance contracts were in place to make sure that any faulty equipment was repaired in a timely manner.
- The department was able to replace broken equipment in a timely manner and to order new equipment if the equipment was clinically needed. Staff we spoke with confirmed this.

Medicines

- Medicines were stored in locked areas, cupboards and trolleys, and were kept at the right temperature.
- The pharmacy department, which was part of the outpatient department, was owned by a private company and did not come under the remit of our inspection.
- PGDs, which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment, were not updated and monitored in line with the trust's policy. The chief pharmacist told us that this was flagged up on the risk register in January 2014 and should be resolved by December 2014.

Records

- Some staff told us that medical records were stored in a number of locations on the site, thus causing difficulties in locating records.
- Some of the locations where records were stored were only accessible by going outside the building. At night, this meant that staff had to leave the building to retrieve records, increasing the risk to their safety. This was recorded on the risk register and the Estates Department were working towards finding a solution.
- Some of the rooms where records were stored were not fit for purpose, with some records stored at both floor level and above an easy-to-reach height. This had been highlighted to managers, but staff were unaware whether any action was being taken to address the problem. This was also recorded on the risk register and the Estates Department were working towards finding a solution.
- Staff and patients we spoke with said there was rarely a problem with records being unavailable for clinics, although on occasions there had been problems with outreach clinics; however, this was usually resolved by faxing information to the clinic. Audits regarding records confirmed that there was no impact on cancelled operations.
- The department used paper records. There was a plan to move to electronic records in the future; however, there was no timescale for the move.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of how to obtain consent from patients. They were able to describe the various ways in which they obtained consent from patients. Staff told us that in the outpatient department, consent was obtained verbally.
- The department had specific paperwork for adults who are unable to consent to investigation or treatment, which included sections about assessing people's capacity, best interests and the involvement of family and carers. This made sure that patients who were vulnerable or unable to give consent were protected from inappropriate treatment. We were given a blank copy of the form, but did not see any in patients' records.
- From the information sent to us by the trust, all relevant staff were up to date with their mandatory training about consent.
- Patients told us that staff were very good at explaining what would happen to them before asking for consent to carry out procedures or examinations.

Safeguarding

- The outpatient department had met the trust's standard of at least 80% of staff attending mandatory training for safeguarding children and young people at Level 2. For Level 1, the rate for medical and dental staff was 80%, and for nursing and midwifery staff the rate was 87%. For Level 2, the rate for both medical and dental staff and nursing staff was 80%. Appropriate staff had children's safeguarding at level 3.

Outpatients and diagnostic imaging

- From the information that the trust sent us, none of the staff working in the outpatient department had attended training about safeguarding vulnerable adults. It appeared that training on safeguarding vulnerable adults was not yet mandatory.
- Staff were able to describe the actions they would take if they had any safeguarding concerns for either children or adults.
- Staff were aware that the trust had safeguarding policies and people they could contact for advice.

Mandatory training

- We looked at data on staff mandatory training, provided by the trust. On the whole, the ophthalmology department met the trust's standard of 80% of staff completing mandatory training. Training was completed using a combination of e-learning and classroom-based teaching sessions and covered areas such as consent, infection control (100% compliant), moving and handling (89% compliant); falls prevention (94% compliant), resuscitation (100% compliant) and safeguarding children and young people (100% compliant). There were no specific figures available for the outpatient department.

Nursing staffing

- The department was staffed by a mixture of registered nurses and healthcare assistants.
- All the staff within the ophthalmology department, including the wards, were flexible to cover increased demand in any area or short-term staffing gaps. This was because staff maintained all of their skills.
- One of the managers told us that bank and agency staff were rarely used. This was confirmed by other staff we spoke with. From information that the trust sent us, 1.56% of the budget in the ophthalmology department was spent on agency staff, but there was no specific data solely for the outpatient department.
- Staff told us that there were sufficient staff to work on clinics. We saw that this was the case: clinics were well organised and patients were seen promptly by nursing staff.
- The managers and other staff told us that they had enough staff with the correct skills to be able to run clinics efficiently.

Medical staffing

- Medical staff were provided by the ophthalmology department. Medical staff undertaking the clinics were of all grades; however, we saw that consultants were always in the department when clinics were running.
- Medical staff told us that they were able to cover clinics for sick or absent colleagues. They told us that clinics were only rarely cancelled. This was confirmed by other staff within the department and patients.
- Medical staff told us that the use of locums within the outpatient clinics was limited.

Major incident awareness and training

- There was a major incident policy, and staff were aware of their roles in the event of an incident.
- We saw evidence that staff were aware of their roles in the event of an incident, because we witnessed a live fire incident. Staff led the evacuation in an organised and appropriate way.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We found that the services provided by the outpatient department were good. Care and treatment was evidence based and patient outcomes were within acceptable limits. The staff in the department were competent, and there was evidence of multidisciplinary working.

Evidence-based care and treatment

- We saw that National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments, with a lead clinician taking responsibility for ensuring it was implemented. Staff we spoke with were aware of the NICE and other guidance that affected their practice.
- We saw that the department was adhering to local policies and procedures. Staff were aware of how policies and procedures had an impact on patient care.

Pain relief

- Staff told us that they were able to access pain relief for patients if this was required before, during or after outpatient treatment.
- Patients we spoke with had not needed pain relief while attending the outpatient department.

Outpatients and diagnostic imaging

Patient outcomes

- The department took part in trust-wide audits, such as about consent and the standard of record keeping; however, most clinical audits were carried out outside the outpatient department in the main ophthalmology department. Where action plans were needed, the sister told us that these were created and monitored at team meetings. The matron was responsible for overseeing the action plans.

Competent staff

- Minutes from team meetings showed that such meetings were held regularly and that staff were able to contribute to them.
- Staff confirmed that they had received appraisals in the last year and that clinical supervision was available for individuals and in groups. There was no specific data relating to appraisals and clinical supervision for the ophthalmology outpatient department. For the ophthalmology department as a whole, all medical staff had undergone appraisals in 2013/14. In 2013/14, 70% of nurses attended an appraisal.

Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatient department; for example, nurses and medical staff ran joint clinics, and staff communicated with other departments such as radiology and with community staff when this was in the interest of patients.
- Specialist nurses ran clinics alongside consultant-led clinics.
- We saw that the department had links with other departments and organisations involved in patient journeys, such as GPs and support services.

Seven-day services

- The outpatient department occasionally ran clinics at a weekend; however most activity within the outpatient department happened between Monday and Friday.

Are outpatient and diagnostic imaging services caring?

Good

During the inspection, we saw and were told by patients that the staff working in the outpatient department were caring and compassionate at every stage of the patient's journey. People were treated respectfully and, whenever possible, their privacy was maintained. Services were in place to emotionally support patients and their families, and patients were kept up to date with and involved in discussing and planning their treatment. Patients were able to make informed decisions about the treatment they received.

Compassionate care

- All the patients we spoke with spoke highly of the care and treatment they received in the department. No negative aspects were highlighted to us.
- During our inspection we saw patients being treated respectfully by all staff.
- Whenever possible, people's privacy was respected; however, on occasion, due to the layout of the clinic, privacy was not always possible. For example, some rooms were divided by temporary screens or curtains. This meant that potentially private conversations could be overheard. Staff spoke quietly to patients who were able to hear well, and tried to stagger patients so that any sensitive information was communicated only when there was privacy.
- Staff made sure that patients were kept up to date with waiting times in the clinic. Patients told us that this meant they were able to take comfort breaks if they needed to.
- We saw very good rapport between patients and staff, especially because many patients had been attending clinics for a number of years. Some patients told us that they knew staff so well that they felt like family. Some staff told us the same about patients.
- Staff were observed to knock on doors before entering. Curtains were drawn and doors closed when patients were in treatment areas.

Outpatients and diagnostic imaging

- Staff told us that the trust had mechanisms for identifying patients with additional support needs, although we didn't see any examples of this in the records we looked at in the department.

Patient understanding and involvement

- We spoke with 33 patients in the ophthalmology outpatient department. They all told us that they knew why they were attending an appointment and had been kept up to date with details of their care and with plans for future treatment.
- Patients felt that they were given clear information and time to think about any decisions they had to make about different treatment options. They also told us that treatment options had been explained to them clearly, with enough information about side-effects and outcomes for them to make informed decisions.
- Staff told us that they encouraged patients to involve their families and loved ones in their care; however, they respected the decision of patients when they chose not to involve their loved ones.

Emotional support

- Patients told us that they felt supported by the staff in the clinic. They reported that if they had any concerns, they were given the time to ask questions. Staff made sure that people understood any information given to them before they left the clinic.
- Staff had created formal and informal networks to link patients with people with similar conditions who were further along their patient journey, for example for patients who had lost or were going to lose an eye.
- Staff told us that formal counselling support was available for patients who needed it.

Are outpatient and diagnostic imaging services responsive?

Good

We found that outpatient services were responsive to needs of patients who used the service. Waiting times were within acceptable limits, with clinics only occasionally being cancelled. Patients were able to be seen quickly for urgent appointments if required. Outreach clinics were run and offered to patients closer to their homes, and some outpatient minor surgery was offered to patients at these clinics.

Mechanisms were in place to ensure that the service was able to meet the individual needs of people such as those living with dementia, a learning disability or physical disability, or those whose first language was not English. Systems were also in place to capture concerns and complaints raised within the department, review these and take action to improve the experience of patients.

Service planning and delivery to meet the needs of local people

- Staff reported that they were supported by colleagues within the wider department at busy times or when there were absences.
- Occasionally, additional clinics were run to meet extra demand; however, this did not happen regularly.
- Some treatment rooms in the department could be used flexibly and were shared between the outpatient department and the A&E department at the Eye Infirmary. This meant that at busy times, the department had some extra capacity to accommodate the additional demand.

Access and flow

- The average time for a patient to wait for a new appointment from referral was 52 days.
- The average time that patients had to wait once they arrived at clinic, before being called in to their appointment, was 13 minutes. This was information collected by the trust.
- The ophthalmology department as a whole was meeting its referral to treatment times. There was no specific data relating to the outpatient department only. The proportion of people being seen within 18 weeks was 99.1%. Half of patients were waiting less than five weeks. Ninety-five per cent of patients were waiting less than 14 weeks.
- The data that the trust supplied did not highlight any concerns about the ophthalmology outpatient department meeting two-week cancer waiting times; however, there was no specific information relating to the ophthalmology department.
- The trust held outreach clinics in a number of locations around the region in premises owned by other

organisations, staffed on rotation by all nursing and medical staff who worked in the main ophthalmology outpatient department. This meant that the clinics were more easily accessible to patients who couldn't access the main hospital easily.
- The did not attend rate for the outpatient department was between 10.6 and 12.6% between August 2013 and September 2014.
- Staff told us that there was always capacity in clinics to see patients who were referred urgently, and that double-booking two patients into one clinic slot happened only rarely. We spoke with one patient who had been referred urgently over the weekend by the Eye Infirmary's A&E department and given an appointment to be seen within two days.

Meeting people's individual needs

- Staff told us that they were able to access translation services if they needed to. On the whole, staff told us that they used translation services; however, one member of staff told us that they sometimes used family members, including children, which is contrary to best practice and the trust's policy.
- The ophthalmology department had information leaflets for patients; however, we noted that some of these leaflets were past their review dates, some by a number of years. Leaflets were available in different languages, on request, if needed.
- Staff told us that when patients with learning disabilities attended the department, they tried to give the patient priority to be seen. They were aware of support that was available within the trust, and also allowed carers to remain with the patient if this was what the patient wanted.
- Some staff told us they had attended training about dementia within the trust and were aware of how to support people at different stages of dementia. One of the sisters we spoke with told us that most patients with dementia were accompanied by carers or relatives, and provisions were made to ensure that patients were seen quickly.
- A canteen was available for patients to use, and the department had access to food and drink for vulnerable patients or patients with conditions such as diabetes. A system was in place to make sure that patients who had attended by wheelchair and were waiting to return home were also able to access food and drink.
- On the whole, the department was able to accommodate patients in wheelchairs or who needed specialist equipment.

Learning from complaints and concerns

- Staff we spoke with were aware of the local complaints procedure and were confident in dealing with complaints as they arose.
- Information about how to access the Patient Advice and Liaison Service or make a complaint was available within waiting areas.
- Managers and staff all told us that complaints and concerns were discussed at local team meetings and any learning was shared across the departments within the Eye Infirmary. We looked at two sets of team meeting minutes; discussions about complaints were on the agenda of each.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint. On the whole, they were happy with their experience in the department. In 2013/14, 14 complaints were raised about the department. Four of these were about aspects of care, and five were about delayed or cancelled appointments.

Are outpatient and diagnostic imaging services well-led?

Good

The outpatient department of Sunderland Eye Infirmary was well-led. Staff and managers had a vision for the future of the department and were aware of the risks and challenges for the department. Staff felt supported and were able to develop to improve their practice. The Eye Infirmary had an open and supportive culture where incidents and complaints were reported, lessons learned and practice changed. The department supported staff who wanted to be innovative and try new services and treatments.

There were some areas where improvement was needed within the department; for example, a number of leaflets in the department were past their review dates, and there was no evidence that patient satisfaction surveys were completed.

Vision and strategy for this service

Outpatients and diagnostic imaging

- The department manager demonstrated a vision for the future of the service and was aware of the challenges faced by the department. This person described how work was already underway to look at the capacity of the service and ways to manage increased demand through reorganising the physical space and expanding. Staff within the service were aware of the challenges faced by the organisation, for example the financial challenges. Most told us they were aware that there was a strategy for the trust, but were mostly interested in the Eye Infirmary.

Governance, risk management and quality measurement

- Strong governance arrangements were in place, which staff were aware of and participated in. The trust has regular clinical governance meetings. At these meetings, staff were given feedback about incidents and lessons learned, for example. The trust regularly produced lessons learned newsletters.
- The trust had systems in place to appraise NICE guidance and ensure that relevant guidance was implemented into practice. It was less clear whether clinical audits of implemented guidance took place.
- The trust had a number of risk registers in place that were speciality-specific and trust-wide. There was an ophthalmic risk register in place. This was reviewed and updated regularly. We saw that action was being taken to manage, minimise or eliminate risks.
- A number of patient information leaflets in the department were past their review dates. This showed that the trust did not have an effective mechanism in place for reviewing information available to patients to ensure that it was still relevant.

Leadership of service

- Staff told us that they found that the managers of the service were approachable and supportive. All the staff we spoke with were extremely happy in their role. Many staff had worked at the Eye Infirmary for most of their professional careers and did not wish to leave.
- Staff felt that managers communicated well with them and kept them informed about the running of the department.
- Staff told us that they had annual appraisals and were encouraged to manage their own personal development. Staff were able to access training and education to further their personal development. For example, the trust ran leadership courses for aspiring managers. One member of staff we spoke with had accessed this.

Culture within the service

- Staff and managers told us that the trust had an open culture. They felt empowered to express their opinions and that they were listened to.
- Staff were encouraged to report incidents and complaints, and thought that these would be investigated fairly.
- Managers told us that they felt well supported by the organisation. Despite being located away from the main trust headquarters, all staff still felt that they belonged to one organisation.
- Managers told us that members of the board occasionally visited the department; however, this was not a regular occurrence.

Public and staff engagement

- We saw that governance arrangements were in place and complaints and comments were discussed at team meetings.
- One of the department managers told us that they were unaware of any patient satisfaction surveys having been carried out within the outpatient department.
- The Friends and Family test related only to inpatients and the Emergency Department.
- No specific information was available from the staff survey relating to the outpatient department. The trust as a whole, however, performed within expectations or better than expectations in all but one element of the staff survey – the number of staff attending equality and diversity training.

Innovation, improvement and sustainability

- Staff and managers reported that they were able to make changes in the way the outpatient department was organised and run. We were given examples of changes that had been made to the way the service was run that had improved the patients' experience and made the clinics run more efficiently. For example, a third pre-clinic room was opened to help ease bottlenecks and improve the flow of patients.
- Outpatient clinics were organised in locations easily accessible to the community, such as in some local health centres.

Outpatients and diagnostic imaging

- Minor surgery was now being performed in outpatient clinics in the community, leading to care closer to home for patients and easing pressure on the Eye Infirmary's outpatient department.
- Staff who worked in the outpatient department worked both in the main department and the community to ensure that they maintained their skills and were able to access supervision.
- The department was involved in discussions about the larger developments to the site as a way of improving capacity.

Outstanding practice and areas for improvement

Outstanding practice

The enhanced recovery pathway for cataract surgery and the role of the primary nurse were viewed as excellent developments of the service and resulted in Individual surgeon's cataract audits showing consistently higher visual acuity outcomes compared with benchmark standards (UK Cataract National Dataset audit).

Areas for improvement

Action the hospital MUST take to improve

Ensure that patient group directions (PGDs), which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment, are updated and monitored in line with the trust's policy

Action the hospital SHOULD take to improve

- Review the storage of medical records within this hospital.
- Review the participation in audits, including clinical audits in the A&E department.
- Develop mechanisms for reviewing and if necessary updating patient information, particularly in the outpatient department.
- Introduce patient surveys specific to the outpatient department.
- Review the arrangements for the role of the Eye Infirmary when dealing with major incident/events across the trust.
- Review the practice of recording complaints in patients' notes in line with best practice guidance.