St Catherine's Health Centre

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

St Catherine's Health Centre is a registered location for Spamedica Ltd. The service is located on the third floor in St Catherine's Health Centre in Birkenhead. The service is accessible by either stairs or lifts and facilities include one operating theatre, consulting rooms, and two waiting areas.

The service provides cataract surgery and yttrium-aluminium-garnet laser (YAG) capsulotomy services for NHS patients over the age of 18 years.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 5 December 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

We rated it as **Good** overall.

We found good practice in relation to surgery:

- The service monitored the effectiveness of care and treatment. Outcomes compared well against the national average and benchmarked well against other providers.They used the findings to make improvements and achieved outcomes for patients that were consistently better than the national average.
- Key services were available seven days a week, if needed, along with a consultant-led 24-hour advice line to support timely patient care. Additional appointments were scheduled at weekends to meet patient demand.
- The service planned care to meet the needs of local people, took account of patients' individual needs and worked with others in the wider system and local organisations to plan and delivery care. People could access the service when they needed it and waiting times were in line with the national standard.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

However, we found areas of practice that require improvement in surgery

- Patient records were not always stored securely.
- Not all policies were reviewed within the documented date.

We found areas of outstanding practice in surgery:

- Staff worked especially hard to make the patient experience as pleasant as possible.
- The service achieved good outcomes that were continually monitored with patients reporting a positive experience.
- The service had an endophthalmitis box on site in case of an emergency.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ann Ford
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	We rated this service good in safe, caring, responsive and well-led and outstanding in effective.

Summary of findings

Contents

Good

St Catherine's Health Centre

Services we looked at
Surgery

Summary of this inspection

Background to St Catherine's Health Centre

St Catherine's Health Centre is a registered location for Spamedica Ltd and is located within St Catherine's health centre. The service opened in 2014. It is a private clinic in Birkenhead, Merseyside. The clinic primarily serves the communities of the Merseyside and the surrounding areas offering cataract surgery and yttrium-aluminium-garnet laser (YAG) capsulotomy services for NHS patients (YAG capsulotomy is a special laser treatment used to improve your vision after cataract surgery). The registered manager had been in post since February 2019. However, the service has had a registered manager in post since it opened.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and one other CQC inspector. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about St Catherine's Health Centre

The service was located on the third floor of a shared building. It has one operating theatre, consulting rooms and two waiting areas and is registered to provide the following regulated activities:

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

During the inspection, we visited all areas. We spoke with 12 staff including registered nurses, health care technicians, optometrist and senior managers. We spoke with eight patients and three relatives. During our inspection, we reviewed five sets of patient records and five staff files.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service has not previously been rated.

In the reporting period July 2018 to June 2019 there were:

- 2,839 visits in the operating theatre
- There were 4,002 day case episodes of care recorded at the hospital.
- There were 5,097 outpatient total attendances.
- All patients were NHS-funded.

Two surgeons worked regularly at the hospital under practising privileges. There were seven registered nurses employed, two optometrist, nine healthcare technicians and five patient co-ordinator who worked across two locations in the Merseyside area.

Track record on safety

- No Never events
- There were no serious incidents, no deaths and no incidents classified as severe harm.
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Meticillin-sensitive Staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-coli

The service had received two complaints between August 2018 and July 2019.

Services provided at the clinic under service level agreement:

Summary of this inspection

- Out of hours call handlers
- Sterilisation / Decontamination
- Interpreter services
- Laundry service
- Pharmacy

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated it as Good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The maintenance and use of facilities, premises and equipment were designed to keep people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave agency staff a full induction.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

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

Summary of this inspection

- Patient records were not always stored securely.

Are services effective?

Outstanding 

We rated it as **Outstanding** because:

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved outcomes for patients that were consistently better than the national average and were benchmarked well against other providers.
- Key services were available seven days a week including a consultant-led 24-hour advice line to support timely patient care. Additional appointments were scheduled at weekends to meet patient demand.
- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.
- Staff offered patients enough food and drink to meet their needs and maintain their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. The service engaged with external stakeholders to enhance the patient experience.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Are services caring?

Good 

We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Summary of this inspection

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

Are services responsive?

Good

We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan and deliver care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to treat patients were in line with the national standard.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint

Are services well-led?

Good

We rated it as **Good** because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Summary of this inspection

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However

- Policies were not consistently reviewed within documented timelines.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

Mandatory training

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

Annual mandatory training for all staff included topics such as health, safety and welfare, conflict resolution, basic life support with automated external defibrillation (AED), moving and handling (level two), information governance, infection control, and fire safety. Training was accessed either via e-learning or within a classroom setting.

Compliance with mandatory training was monitored by a designated lead in training who was based at another location. Data provided at the time of inspection showed 100% compliance for all clinical and non-clinical staff.

Staff were expected to complete mandatory core of knowledge laser safety training every three years. Data provided showed that 14 of the expected 23 staff had completed the training within the past three years, in addition to four members of staff who had completed it in October 2016.

There were five members of staff who had not completed the training, this included four who had recently been recruited. The hospital manager told us since the recruitment of the new external laser protection advisor (LPA) they were looking at arranging further refresher training of core of knowledge training.

Safeguarding

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

The hospital manager was the safeguarding lead and had completed level three in safeguarding of vulnerable adults. The director of clinical services was a registered nurse and we were provided with evidence that they had completed level four safeguarding training after our inspection.

All staff had completed safeguarding children (level two) and safeguarding of vulnerable adults (level one and level two) and apart from one recently recruited trained nurse who had not yet completed safeguarding of vulnerable adults level two.

Four members of staff including the hospital manager had completed level three in safeguarding of vulnerable adults.

Training in safeguarding was provided via e-learning, however, following our inspection we were informed the director of clinical services was looking into arranging face to face training for staff.

Staff had access to a safeguarding policy for adults and a separate policy for children that had recently been updated. The policies included guidance for staff in relation to types of abuse, individual's roles or responsibilities, what staff should do if a person discloses they are being abused or they suspect abuse; also, there was reference to an app held on computers across the organisation with contact details of local authority safeguarding teams. However, the safeguarding policy for children we reviewed referenced the intercollegiate guidance 2014 rather than the updated 2019. It did not include reference to working together to safeguard children (2018).

Good

Surgery

During our inspection, staff we spoke to understood their responsibilities around keeping patients safe and told us they would escalate any concerns they had to their manager.

We observed advice regarding escalating safeguarding concerns displayed in the waiting area and consulting rooms and staff told us they could access contact details of local authority safeguarding services on the computer.

The service confirmed there had been no safeguarding referrals in the last 12 months.

Cleanliness, infection control and hygiene

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

The provider had a designated lead (chief operating officer) along with a recently recruited nurse lead in infection control. We were told there was nominated link staff member who had received additional infection control training.

The hospital manager confirmed there was an agreement in place with a microbiologist to work across the organisation to give advice and guidance.

Staff had access to an infection control policy that provided guidance for staff follow for example hand washing and waste disposal along with management of incidents such as sharps injuries.

All areas we visited along with equipment were visibly clean.

Patients had access to personal protective equipment such as gloves and surgical attire. Staff were observed to adhere to the arms below elbow policy in clinical areas.

Staff and patients had access to hand gel and during our inspection we observed staff washing their hands and cleaning equipment before and after patient care.

Data provided showed there had been no incidences of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C.Difficile) or E-coli reported from July 2018 to June 2019.

The service had service level agreements in place with external companies for cleaning and laundry services.

The provider had a service level agreement in place with an external company to check air flow systems in theatre. We observed a report from March 2019 that concluded all test results were satisfactory.

Environment and equipment

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

Staff had access to laser safety local rules specific to the service to support staff and to ensure the safety of staff and patients using the YAG laser were stored within the room that laser procedures were performed. This included the use of goggles and signage about laser safety and we observed these were available during our inspection.

There were processes in place to ensure the traceability of lens implants. Each lens had four identity stickers. Following surgery, one was placed in the patient's records, one in the operations' register stored in the theatre, one placed in the track and traceability register and the fourth was placed in a lens replenishment folder to aid stock control.

Electrical safety testing was completed by an external provider. We reviewed the asset log and found all equipment had been tested within the expected date.

In each room, environmental temperature was checked and recorded daily. There were also daily check lists for each room. These had been completed in each room visited. In theatre, humidity was checked daily also. However, we observed this was recorded on the room temperature and fridge recording sheet that did not document the expected humidity range. We raised this at inspection. The area manager confirmed there was no specific form to log this information, but they were going to trial a new system that recorded the temperature and humidity in theatre electronically.

Resuscitation equipment, including a defibrillator was located within easy reach of all rooms at the location. We reviewed daily and weekly checklists for the previous three months and observed these had been completed.

However, we observed consumables (green needles and a nasopharyngeal tube) had exceeded the expiry date of November 2019. We raised this at inspection and these were removed and replenished immediately.

We observed that the disposal of sharps, such as needle sticks followed good practice guidance. All sharps containers we observed were dated and signed upon assembling them with the temporary closure in place apart from in theatre as this was being used at the time.

Assessing and responding to patient risk

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

There was an optometrist who was the designated laser protection supervisor (LPS) at this location. The service had recently recruited a new external laser protection advisor (LPA) who had conducted an audit and a RAG risk assessment in November 2019. We were provided with an updated risk assessment and observed actions had either been completed or were going to be discussed at the clinical effectiveness group meeting in December 2019.

Information relating to the procedure and process was sent out to the patient and we were told if any additional information was required relating to the patient, the referring clinician were contacted.

Staff had access to guidance in relation to patients with specific conditions such as diabetes and advice on the process for patients with latex allergies. During our inspection we observed staff asking patients regarding current medical conditions and allergies and observed a patient wearing a red risk band to highlight an allergy.

Data provided stated all patients were required to have a pre-assessment performed to provide information to the surgeon and ensure they were suitable for surgery, the process included:

- Ocular coherent topography (OCT) scans on patients who had presented with or had any previous retinal pathology.
- A detailed eye examination pre-operatively. The images produced could identify other eye related disease for diagnosis.
- A biometry test to calculate the power of the lens that will be implanted during the cataract operation.
- An A-scan test that measured the length of the patients eye to determine the lens selection for patients with dense cataracts.
- An epithelial cell count (ECC) was performed before surgery for patients who were at higher risk of developing corneal issues post operatively.
- Corneal topography map on those patients who had presented with corneal problems pre-operatively to assist with prognosis.
- A couch test to ensure they could lie flat for a period of time during their procedure.

Patients who were at a higher risk of complications were identified during their pre-assessment. We were told patients with a risk score of 8% and above of posterior capsule rupture were added to the complex case list with a specialist vitreoretinal surgeon performing the procedure at another location in the north west.

Data provided showed seven complex patients had been redirected to the other location for their treatment from July 2018 to June 2019.

The service had recently introduced daily safety huddles to discuss staff responsibilities, theatre lists and any concerns.

Operation sites were clearly marked and a revised version of the World Health Organisation (WHO) Surgical Safety Checklist for cataract surgery was used to keep patients safe.

We were told quarterly audits of the WHO checklist were performed and observed 100% compliance for audits performed in February, April and July 2019.

The service offered a 24-hour clinical emergency support service for patients. Calls were triaged by an optometrist and advice given and any concerns were escalated to a specialist doctor on call.

Data showed that all qualified nursing staff had completed training in advanced life support in 2018. However, we were told training requirements for life support had changed and a recent decision had been made that it was more relevant for staff to attend immediate life support training. Data provided showed seven qualified nurses had attended this training so far.

The hospital manager told us simulation emergency exercises including cardiac arrest were facilitated by a member of the resus council and we observed this was documented as part of the audit matrix with a recorded pass in January 2019. The hospital manager confirmed the service also passed one performed in September.

The hospital manager told us simulated emergency exercises were performed twice a year but there were plans to increase to quarterly. We observed, in the cardiopulmonary resuscitation policy, that there should be a minimum quarterly emergency simulation conducted.

Each treatment room had a phone that had a tannoy facility. In the event of an emergency, a call could be made to alert other staff at the location.

Nursing and support staffing

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

The service had seven registered nurses, nine health care technicians, two optometrist and five patient co-ordinators who worked across two locations in the Merseyside area.

We were told at the time of inspection there was 1.5 whole time equivalent vacancies for registered nurses and interviews were due to be conducted the following week.

We reviewed examples of rotas and saw that it was clearly identified what activities were planned including any new starters or training as well as clinics and surgery. Staff were allocated to the planned activities.

Staff sickness for registered nurses during August 2018 to July 2019 was 0%, apart from October 2018 (8%) and April 2019 (2%). For the same time period staff sickness for untrained staff was 0% apart from September (5.5%), December 2018 (2.5%) and April 2019 (2%). The service did not have a target.

Data provided showed from August 2018 to July 2019 the use of agency trained nurses in theatre ranged from 0% to 5% apart from September 2018 that reported 20%. For the same reporting period the use of agency trained nurses in outpatients was reported as 0% apart from May 2019 (7%) and June 2019(13%). No other staff groups reported any agency use.

The hospital manager confirmed agency staff was mainly used in theatre and the same agency staff were used. No other staff groups reported any agency use.

Data showed there were no unfilled shifts from May 2019 to July 2019.

From August 2018 to July 2019 turnover for all staff in theatre was 0%.

Medical staffing

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

The service employed 12 consultant ophthalmologists under practising privileges, of those six had performed between 10 and 99 episodes of care and six had performed over 100. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, these were not always stored securely.

Patient details were collected and stored on the organisations electronic records system. This included information following pre-assessment, theatre, discharge and post-operative care. Paper records were maintained for consent, demographics, copy of biometry, outcome forms and referrals. All scans could be viewed electronically. Biometry scans could be viewed electronically as well as printing of hard copies if required at the hospital.

In the three months prior to inspection, 100% of records were available for appointments.

On the day of inspection, we observed a set of patient records in a clear plastic cover stored in plastic filing tray on

top of the reception desk. We observed reception staff within close proximity and were always present at the reception desk. However, there was still a risk that patient records could be viewed or accessed by unauthorised persons. We raised this at the time of inspection and the patient records and plastic filing box were removed to behind the reception desk.

Computer monitors could only be viewed by reception staff.

Records followed patients and stayed in rooms with staff.

Confidential waste was placed in shredding bins available on site.

Data provided stated in the event of a misplaced medical record, the patient would be re-consented on the day of surgery and diagnostics and referrals could be re-printed. Any misplaced or missing patient record incidents would be logged on the electronic incident reporting system and an investigation commenced.

We reviewed records for five patients and found they had been completed appropriately.

A records audit, in March 2019 and June 2019 reported compliance of 95% and 90%. We reviewed an audit of 20 patient records performed in July 2019 and observed compliance was 90% with three WHO checklists not signed by the surgeon and one with no printed name. The hospital manager told us following this audit , amendments had been made to the WHO checklist. However, we did not observe a version control on the WHO checklist and therefore it wasn't clear what version what being currently used.

Data provided stated designated staff with authority arranged for patients medical records to be removed from site in secure locked transport carriage boxes by the organisations internal transport service. Each transferred patient record was recorded by completing a file transfer form along with entering the details on the organisations patient administration system (PAS) system with the date the request of transfer and the date received at specified location. The recipient confirmed receipt of the patient record as soon as it arrived by signing the file transfer form. Confirmation the patient record had been stored in the patient records area of the required location was also recorded.

All paper records of discharged patients were scanned and indexed to be retrieved on request for planned follow up appointments. All clinical diagnoses and episodes of treatment records were stored electronically and were available at all sites in the case of an unplanned follow up.

We were informed patient records were sent externally by courier via recorded delivery. A log of all records dispatched from the patient records department included the date sent, name, designation and location of person to whom the records were sent, service username and volume of records sent.

Medicines

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

The service used topical and local anaesthesia to the eye only. Drops were prescribed using patient specific directions (PSD). These were administered by health care technicians who recorded on the paper PSD and also in the patients electronic record.

We reviewed four PSD and found these to be completed including date, surgeons signature and name and GMC number printed.

We reviewed five prescriptions and noted that staff had signed to confirm they had administered the eye drop. However, we observed on one prescription both the nurse and surgeon's signature were illegible. Names were not printed and on another prescription the nurse's signature was illegible with no printed name, therefore it was not clear who had administered the medicines. On each prescription there was an area to document the surgeons GMC number. However, this was not completed in all prescriptions we reviewed. We raised our observations on inspection.

The medicines management policy was reviewed and referred to patient group directions as well as PSD's. The company were planning to implement PGD's following agreement from local commissioning authorities. A patient group direction (PGD) is a written instruction that includes the administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The service had plans to introduce PGD's following consultations with commissioners.

There was a service level agreement in place with an external pharmacy provider.

The service stored diazepam to be available for patients who were identified as anxious prior to surgery. It was stored appropriately, and records completed for checking and administration. The prescribing of diazepam was included on the prescription chart with other medicines given following PSD's. We observed a recently updated version showed clear documentation of what time the diazepam was administered if it was required.

Data provided prior to inspection confirmed there was no controlled drug accountable officer (CDAO). However, at the time of inspection we were provided with data that confirmed the director of clinical services and the hospital manager had recently attended accountable officer training.

The medicines we sampled, in cupboards and fridges, were all within their expiry dates.

The temperature of the clinical fridge was monitored and recorded appropriately, including the maximum and minimum ranges. The hospital manager told in August 2019 they had noted the recordings had been documented as out of range and were not always being escalated. The hospital manager told us they took immediate action and sought advice from the pharmacist and had the fridge was checked by the manufacturer who confirmed there were no issues. The service had recently received a new fridge. We observed in team meeting minutes that staff were reminded to escalate any out of range temperatures immediately.

During our inspection we reviewed fridge temperature checks from October 2019 to December 2019 and observed these were recorded within range.

A medicines audit was carried out in September 2019, by the external pharmacy company where a number of recommendations were made. The action plan showed that the majority of actions had been completed. We could not see evidence if another audit had been planned.

Patients were provided with discharge medicines of drops. These were labelled for dispensing and included manufacturer's instructions. Staff checked that patients were confident with administering the drops.

Trained nurses received training in dispensing medicines and data provided showed four nurses had completed the training with an additional recently recruited nurse planned to attend the training as part of their competencies.

Data received showed between March 2018 and February 2019 there was one near miss medicine incident relating to a patient who had a documented allergy. The incident resulted in no harm and we observed this has been reported as an incident, investigated and action taken to prevent it from occurring again.

The hospital manager told us there had been another medicine incident reported recently in relation to incorrect labelling that was identified on a second check. This resulted in no harm and we observed action had been taken to prevent it from occurring again.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

Safety alerts were managed and monitored by the director of clinical services. During our inspection we observed a recent safety alert had been sent out and appropriate action had been taken by the hospital manager.

Guidance for staff to follow in relation to reporting and managing incidents was documented within the serious untoward incident policy and the critical incident policy. The serious untoward incident policy included responsibilities around duty of candour and we observed this was due to be reviewed April 2019.

Incidents and near misses were reported on the electronic reporting system and the hospital manager was responsible for review and if required, investigating.

The service had reported no serious incidents or never events reported from July 2018 to June 2019.

Good

Surgery

Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic barriers are available as at a national level and should have been implemented by all healthcare providers.

Data provided prior to our inspection showed from July 2018 and June 2019 the service reported 42 clinical incidents, of those

- 38 resulted in no harm
- 4 low harm.

During the same reporting period, the service reported two non-clinical incidents in relation to power failure.

Staff received feedback from investigation of incidents and lessons learned were shared.

Staff we spoke to were aware of the principles of duty of candour and had access to a recently revised policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents 'and provide reasonable support to that person

Are surgery services effective?

Outstanding ☆

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

The service followed the Royal College of Ophthalmologists (RCOphth) standards.

There were policies and standard operating procedures in place to support practice on the organisations intranet that was accessible to all staff.

The service carried out quarterly clinical audits that covered key topics. We were told any audits that were less than 90% compliant, had actions identified, and the audit was repeated one month later.

The clinical audit process was undergoing a national review as part of a recently drafted clinical governance strategy.

The service provided an audit matrix that included hand hygiene, clinical room audit, infection control, fridge temperatures and emergency equipment in theatre. Data showed compliance above 90% on audits performed from January to July 2019 apart from two audits in April (theatre trolley, emergency drawer and IOP Drawer) that reported a compliance of 80%.

The services referral to treatment target was six to seven weeks. Activity was monitored through the operations meeting and the hospital manager reviewed activity on a daily basis and actioned or escalated any issues.

Nutrition and hydration

Staff offered patients enough food and drink to meet their needs and maintain their health.

Hot and cold drinks and biscuits were available in waiting areas free of charge for patients and those accompanying them.

Pain relief

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

Patients were administered local anaesthetic and pain relief during their procedure.

Following surgery, patients were asked about their experience including pain and comfort and this was fed into the patient reported outcome measures (PROMS).

Data provided showed from July 2018 to June 2019 2220 patients were asked about pain. Of those, 2135 of patients reported no pain, 78 reported mild pain, six reported moderate pain and one patient reported severe pain. We were told the hospital manager received an email alert if patient's pain was recorded as moderate or above and the hospital manager would then go and speak to the patient. The area manager confirmed the severe pain was recorded in error. However, if they identified any concerns such as a headache they would ask the surgeon to review.

Patients were provided with a leaflet which gave advice on expected post-surgery symptoms and guidance if excessive or increased pain is experienced. During our inspection, we also observed staff discuss the contents of the booklet to the patient.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved outcomes for patients that were consistently better than the national average.

The service submitted data for inclusion in the National Ophthalmic Database Audit (NODA).

Data submitted by the provider showed the service had achieved significantly better outcomes for patients compared to national standards for the 2,472 patients who had cataract surgery performed from July 2018 to June 2019:

- the adjusted posterior capsular rupture rate was 0.3% (National 1.1%)
- the visual acuity loss rate was 0.4% (National < 0.9%)
- 6/12 vision or better 96.82% (national target >95%)
- refractive outcome within 1D 93.16% (RCOphth >85%).

Outcomes were benchmarked across the organisation, as well as externally, that identified good practice and areas for support and focus.

The provided submitted data to The European Registry of Quality Outcomes for Cataract and Refractive Surgery (EUREQUO). This was a database for providers, to benchmark outcomes across Europe.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

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

New starters attended a corporate two day induction that was delivered at the providers headquarters. The induction included shadowing a patient through their journey.

Managers made sure staff received any specialist training and induction for their role.

The service had a skills matrix with role allocated competencies for each member of staff to complete for example training in specific equipment and administering eye drops.

The training was facilitated by a designated training team at the providers headquarters.

During our inspection we observed staff being supported through their competencies. Staff told us there was a buddying up system and there was always someone around to ask any questions if they needed any advice.

Newly appointed surgeons had a period of supervised practice under a lead surgeon. The service monitored quarterly comparative complications, infection rates and patient bedside manner for surgeons using a RAG rating tool. Any concerns were managed directly.

Surgeons and optometrists performance was monitored and reviewed at governance and medical advisory committee meetings that focussed on outcomes as well as patient experiences.

Staff told us they felt supported to develop their roles and skills.

Data showed all staff had received their annual appraisal.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. The service engaged with external stakeholders to enhance the patient experience.

During our inspection we observed good interaction and a positive working environment with all staff and patients.

Effective working with external stakeholders, commissions, opticians and GP's.

Multidisciplinary daily morning huddles and debriefs were held in the hospital led by the clinical lead on the day, normally the registered manager to plan and review the day's activities collectively.

Seven-day services

Key services were available seven days a week including a 24-hour advice line to support timely patient care. Additional appointments were scheduled at weekends to meet patient demand.

The service was opened six days a week and the area manager told us this could be extended to seven days. However, this had never been required.

Good

Surgery

Post-operative patients had access to a 24-hour, seven day on-call service for advice and assistance. The phone calls were triaged by nurses and optometrists.

There was an on-call team consisting of a consultant and registered nurse who could see the patient at a hospital for review or treatment.

Health promotion

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

Patients were given discharge advice both verbally and written leaflets that included advice about keeping the eye clean as well as driving or operating machinery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The provider had a Mental Capacity Act policy and a consent policy that provided guidance for staff to follow.

Data provided showed from January 2018 all clinical staff and non-clinical staff had attended training in the mental capacity act that. Data provided stated staff were expected to attend the training three yearly unless there was a change in legislation.

We were told senior optoms, two trained staff and two health care technicians were scheduled to attend a 'best interest decision course' in December 2019.

If patients lacked capacity to make their own decisions staff assessed care in the best interests of patients and involved their representatives and other healthcare professionals appropriately. This included referring back to the NHS for care and treatment, including an independent mental capacity advisor (IMCA) where appropriate.

The service used a two-stage consent process. This including an initial consent being taken at the pre-assessment stage and a second stage by the consultant on the day of surgery.

Staff made sure patients consented to treatment based on all the information available.

Written consent was obtained prior to surgery and we observed consent clearly documented in the four records we reviewed.

During our inspection, we observed practice of obtaining consent and noted staff checked patients understanding of their reason for attendance.

There was an interpreter service available to help with consent for patients whose first language was not English, these were pre-booked to provide either face to face or telephone support. Staff told us, they would not use family members for interpretation.

Are surgery services caring?

Good

Compassionate care

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

Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness and one patient told us they experienced back problems and staff had taken the time to ensure they were comfortable on the operating table and had placed a pillow under their legs.

Compliments were recorded on the organisations electronic reporting system shared at clinical governance meetings.

We observed seven patients, during consultations with different staff members and observed all introduced themselves to the patient and explained all care and treatment.

Patients were respected and their privacy and dignity was maintained. We observed staff communicating with patients and their families in a respectful and considerate manner.

Good

Surgery

Engaged signs were on consulting room doors to show a patient was in a consultation. However, we observed this did not always stop staff knocking and walking in.

On the day of our inspection, staff told us a patient who had previous surgery on one eye was booked in to attended for pre-operative assessment for the other. However, they believed they were coming in for surgery on that day. Staff told us the patient and family were distressed due to ongoing health concerns and arrangements were made for the patient to have surgery on the same day.

The service submitted feedback data to the NHS Friends and Family Test. Between February 2019 and July 2019, between 99% and 100 % of patients would recommend the service, with a response rate ranging from 86% to 95%.

Emotional support

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

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

One patient told us they felt anxious prior to attending for surgery. However, just by talking to the staff they told us felt much calmer and had the opportunity to ask questions that were worrying them.

During our inspection, we observed patients being offered a 'hand holder' during their procedure and staff gave reassurance throughout their procedure.

On the organisations website we observed there were videos of previous patient who described their experience of the patient journey.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand.

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

During our inspection, we observed staff explain clearly to the patient what to expect at each stage the process and offered reassurance. Staff ensured patients were comfortable and did not feel rushed.

Patients we spoke with felt fully informed about what to expect prior, during and following their procedure.

During our inspection we observed the receptionist chaperone a patient to a family members car as the family member had very young children with them.

A chaperone policy had recently been introduced that explained staff roles and responsibilities and arrangements for a chaperone and hand holders were available during their procedure. However, we did not see any signs in any of the areas we visited explaining a chaperone service was available. During our inspection, patients had attended their appointments with their family.

Are surgery services responsive?

Good

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population.

The service treated adult patients only, over the age of 18 years and only elective patients according to the parameters set by their local commissioners.

Facilities and premises were appropriate for the services being delivered. However, reception staff told us they had to assist staff from another provider to access their meeting rooms by pressing a buzzer located at the reception desk to open the door and on occasions this impacted on their time assisting patients.

There were two waiting areas with the larger waiting area and reception desk located in open space, with staff from another provider passing to access their meeting rooms. There was also a smaller private waiting area that could only be accessed by Spamedica staff.

The hospital manager told us they had received no complaints from patients in relation to waiting for their surgery in the open waiting area and that patients had expressed a preference to waiting in the larger area rather than the smaller one. This was confirmed with the five patients we asked.

Patients confirmed they were given a choice of appointment to suit their needs.

During July 2018 to June 2019 there were:

- 2,839 visits in the operating theatre
- There were 4,002 day case episodes of care recorded at the hospital.
- There were 5,097 outpatient total attendances.

Information was available on the organisations website including how to get to the location via public transport or car. Car parking facilities were available.

The service was routinely open six days per week, and we were told extra lists could be added if there was an increased demand.

The provider website included patient stories that could be viewed at home.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The hospital manager confirmed free patient and carer transport was offered to patients who lived more than ten miles away. Drivers collected patients from their home with a reminder the day before of the expected time.

The service could accommodate bariatric patients up to the weight of 250kg who were able to transfer independently on the theatre table. The area manager told us the organisation were looking at the possibility of providing additional resources to be able to offer the service out to people who required additional support, such as hoisting onto the theatre table and confirmed the director of clinical services had recently met with an external company to discuss trialling a mobile hoist to use in theatres. Lifts and disabled toilets were clearly signposted and available along with wheelchairs, which we were informed were suitable for bariatric patients.

There were 17 members of staff who worked across this and another location who were dementia champions and had completed dementia training.

For patients whose first language was not English,an interpreter service was available either face to face or by telephone. These were pre-booked when needed.

Written information was available in languages other than English, although the organisations website did not include a translation facility.

Leaflets could be accessed in formats such as larger print, however; there was no pictorial leaflets for patients with a learning disability or limited reading skills.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and targets.

Referrals were received by phone and we were told patients were contacted within 48 hours to book an appointment.

Following confirmation of their appointment, patients were sent out written details of their appointment, this was then followed up by a telephone call reminder 48 hours prior to their attendance.

Patients were offered a choice of appointment, including weekends. The services referral to treatment target was six to seven weeks. Between July 2018 and June 2019, the average waiting time from referral to pre-assessment clinic was 26 days. For the same time period, the average waiting time between pre-assessment clinic and surgery was 25 days.

Waiting times from time of arrival to departure through each stage of the patient journey were monitored as part of

key performance indicators to monitor and action if there are areas that need addressing. Data provided showed during July 2018 and June 2019 patients waited on average between 16 and 23 minutes to be seen in the pre-assessment clinic and on average patients waited on average 17 minutes to be treated for YAG and 36 minutes for cataract treatment.

During our inspection we observed a stand with information relating to a delay in waiting times. Staff told us this would be displayed within the waiting area for patients to see if there was an excessive delay.

The service had recently introduced a standard operating policy for the management of patients who did not attend their appointments this included contacting the patient and their next of kin and sending a letter out with a further appointment.

Data provided showed during July 2018 to June 2019, 39 procedures were cancelled due to non-clinical reasons, of those 4 were offered another appointment within 28 days.

The area manager told that the appointments were cancelled due to a failure of the uninterrupted power supply (UPS) across the location that was managed by another organisation and confirmed patients were transferred and seen at another location in Merseyside.

We were told following the incident, an uninterrupted power supply had been sought specifically for the service as an extra contingency in case of failure again across the building.

During July 2018 to June 2019 there were 62 procedures cancelled due to clinical reasons, of those

- 39 received surgery on another day
- one was referred back to the optometrist
- 25 were referred back to their GP

For the same reporting period, data provided prior to inspection showed there were no unplanned returns to theatre.

Learning from complaints and concerns

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

The service had a complaints policy that provided guidance for staff to follow in receipt of a verbal or written complaint along with individual responsibilities and actions to take within set timelines.

The chief operating officer reviewed any investigation and the hospital manager issued the final response letter to the patient. The organisations electronic system included the investigation, relevant statements, documents and actions or learnings. Trends and learning were shared at senior meetings and cascaded to staff at daily huddles, email, newsletters and team meetings.

During our inspection we observed complaints leaflet in the reception area and information on the website as how to complain to the service along with details of the Parliamentary and Health Service Ombudsman (PHSO) if the complainant wasn't satisfied with the response.

The hospital manager knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Data provided showed the service received two complaints during August 2018 and July 2019 and were observed these had been investigated appropriately and neither had been upheld.

Managers told us they shared feedback from complaints with staff and learning was used to improve the service.

Are surgery services well-led?

Good

Leadership

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

Good

Surgery

The organisation had a board that consisted of a chief executive officer, chief operations officer, chief implementation officer, chief finance officer, medical director and chief peoples officer.

The service was led by the experienced hospital manager who had recently been promoted to area manager. However, they remained as hospital manager whilst the newly recruited hospital manager was being inducted.

The recently recruited manager had worked at the organisation for four years and told us they felt 'massively supported' in their transition from healthcare technician to hospital manager and told us senior managers visited the site to offer support when the hospital manager was on annual leave.

There was a planned period of training, induction and mentorship. Both the recently recruited hospital manager and area manager told us they felt supported within their role by all levels of managers.

All staff we spoke to told us managers were visible and approachable.

Vision and strategy

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

The organisation vision and strategic objectives was every patient, every time, no excuses, no exceptions. Their aim was to deliver a world class service by excelling in the care standards to ensure all patients are cared for safely and effectively and to be the patients first choice for cataract assessment and surgery.

The organisation values were included in induction for all staff.

Staff we asked were aware of the vision and strategic objectives and told us the service was very 'patient focussed with emphasis on putting the patient first and patient experience'.

Culture

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

Staff felt fully supported by managers and we were provided with examples.

Staff told us they felt valued and were comfortable in raising concerns directly with their peers and manager and staff shared examples of when this had happened.

Staff were proud of the department they worked in and providing the service to patients.

During our inspection we observed positive working relationships and engagement with staff and patients.

Governance

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

There was a process and policy in place to monitor and review practising privileges for medical practitioners to ensure standards were adhered and concerns escalated. This had been reviewed by the medical advisory committee (MAC). Surgeons were interviewed and their outcomes for patients reviewed prior to forwarding recruitment documentation. New applications were received with a process where individual applicants were reviewed and accepted to supervised practice assessment, before having practising rights approved. The lead surgeon observed the applicants during a trial operation list followed by supervision with a limited number of patients initially increasing to a maximum of 24.

The human resources team monitored individual consultant files, checking registration with the General Medical Council (GMC), professional indemnity, appraisals and responsible officer reports. The MAC reviewed the monitoring processes with a responsible officer on the MAC.

Good

Surgery

Following a recent inspection at another location, the provider had recently updated the recruitment policy to reflect changes that included reference and health checks and were conducting risk assessments of medical staff employed under practising privileges.

During our inspection we reviewed five staff files and found evidence of a disclosure and barring check, health checks, references and employment history. However, there was just one reference in one surgeons file and we observed the provider had completed a risk assessment.

There was a clear governance structure with clear roles and responsibilities.

A director of clinical services had recently been appointed to focus on clinical leadership, quality and governance supported by the quality assurance and risk manager (QARM). The director of clinical services reported to the chief operating officer.

As part of the organisations clinical governance strategy there was a planned review of the policies, procedures and processes and we observed some had not been reviewed within the documented date including consent policy, clinical governance policy and the compliance and retention of records policy that had last been reviewed in May 2018 but did not have a documented date for next review.

The director of clinical services told us they were going to introduce a new electronic system where policies would be uploaded, and it monitored which staff accessed along with the time to read each policy.

Significant incidents and themes were reported and discussed at the organisations national clinical governance and clinical effectiveness bi-monthly meetings, medical advisory and health and safety committees.

We were told complaints were monitored by the executive assistants, chief operating officer and director of clinical services. However, we observed complaints was not a standardised item on the agenda in the three clinical governance meeting agenda's we received.

The clinical audits were discussed at clinical governance meetings. Changes to policy or practice were implemented by the clinical effectiveness group.

Monthly operations team meetings and clinical governance meetings included representatives from all the organisations locations. Regular agenda items were discussed with actions identified.

Service level agreements between the provider and suppliers were managed by the facilities team. We were told the agreements along with dates for monitoring were available on an internal system that could be accessed by the hospital manager. We requested service level agreements for the location and were provided with three in addition to one quote. We noted none of the service level agreements were signed or dated by either party therefore it was not clear if both parties had agreed to the service or if the contracts were indefinite.

There was a service level agreement in place with the recently recruited laser protection advisor (LPA). However, we observed this had not yet been signed. Local rules were in place that authorised operators of the YAG laser and support staff were required to read and sign. The area manager told us only staff who had been in the YAG laser clinic since the recent introduction had signed the local rules. We observed these had been signed by seven members of staff including the medical director, hospital manager and healthcare technicians.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Senior managers were committed to providing quality care for patients. Surgical performance was monitored quarterly on a dashboard that included outcomes of surgery and bedside manner using a RAG rated system.

The service had introduced a structure that encouraged participation from staff at all levels with meeting decisions cascaded to al staff and managers open to staff suggestions.

The service had a business continuity plan that reflected actions to take in response to untoward events effecting service delivery such as equipment failure or cyber-attack.

Good

Surgery

There was a process in place for any new risks added to the risk register to be escalated to senior managers.

The service had a risk register. We reviewed the risk register and saw that each risk was accountable to the hospital manager. Control measures in place to reduce the risk along with the date the risk was added and review date. All risks had been added in 2019 with the majority documented as potential incidents or issues that may occur rather than a current actual risk. For example, 'sub-optimal treatment of any patient', premises unexpectedly not available and patients becoming unwell within their care.

Team meetings were held monthly at either one of the two locations in Merseyside. The hospital manager told us the invite was sent out to all staff and the agenda was open to give staff the opportunity to add anything they wished to raise or discuss.

We reviewed minutes from three team meetings and observed in one of the minutes there was no recorded date, location of the meeting, who attended and chaired the meeting. All minutes consisted of a list of points that were discussed, and these included operational and governance issues, but we did not see evidence of timelines against actions or of actions being completed.

Managing information

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

Patient details were maintained initially using a combination of paper and electronic systems. Following discharge, paper records were scanned onto the electronic systems. These were backed up in case of accidental failure.

Staff could access information via the organisations intranet and via emails. Staff we spoke with said that managers were very responsive to any queries.

During our inspection we observed a notice board displaying information including audit results, National Ophthalmic Database Audit (NODA) results and patient feedback.

Minutes from operational meetings included concerns about data breaches across the organisation, such as letters being sent out with other patient letters and also theatre list in with these letters. The hospital manager confirmed there had been no data breaches at this location.

The service submitted 100% of their data to benchmark and monitor their clinical outcomes nationally.

During our inspection we observed information relating to General Data Protection Regulation visible within staff areas.

Engagement

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

We were told staff feedback was encouraged through six monthly staff surveys and forums. Hospital roadshows were held where the board listened to staff concerns, sharing planned changes in response including improvements to the staff travel policy.

There was a whistleblowing and raising concerns policy, however, this was passed their review date of May 2019.

Education evenings and events for community optometrists were held to improve continued care and cross provider engagement to support ongoing patient care in the community.

We were told the organisation liaised with local charities to support continued care in the community.

Staff received updates via the organisations intranet, weekly emails, monthly newsletters and team meetings.

The organisation had achieved gold for Investors in People valid until 2021.

Social events were held throughout the year to celebrate any success.

Good

Surgery

Staff told us the company held corporate events where all staff were invited and encouraged to engage with each other and staff from other locations at the annual summer and Christmas social events. Staff told us they enjoyed the events.

Staff told us there was positive engagement with their peers and managers and gave us examples of when managers had supported them.

The service encouraged and gave patients the opportunity to feedback about their care and experience.

Learning, continuous improvement and innovation

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

During our inspection we observed an 'endophthalmitis box' stored securely within the theatre. This allowed for immediate access to all equipment including antibiotics to treat the serious sight threatening complication. The medical director told us having all the equipment on site ensured patients received timely care. We were told surgeons had received training as this was a rare complication. The organisation had made a DVD for surgeons to watch to refresh their knowledge. The medical director told us they had received positive feedback from staff.

The medical director was passionate about their work. They had carried out research into social deprivation and the impact it is has on cataracts. This has been presented at ophthalmic conferences and was published in a national journal for the medical profession.

The provider has been nominated for a national antibiotic guardianship award for supporting the appropriate use of antibiotics for cataract surgery.

The service had shared videos of cataract surgery with colleagues that were accepted in the European Society of cataract and refractive library.

The medical director was planning to introduce across the organisation some additional simulation training sessions for surgeons to enhance skills.

By monitoring outcomes and patient satisfaction, the service was committed to continuous improvement.

The organisation had introduced an optometry accreditation scheme. This involved inviting local optometrist to the location for a presentation about services provided. Following any surgery, if routine, patients could be followed up by an accredited optometrist rather than needing to visit the location.

Outstanding practice and areas for improvement

Outstanding practice

- The service achieved good outcomes that were continuously monitored with patients reporting a positive experience.
- The service had an endophthalmitis box on site in case of an emergency.
- Patients were provided with the organisations "patient stories" DVD where previous patients described their experience to help relieve anxiety. Videos were included in the organisations website.
- The service provided free transport to patients who lived within a set distance from the location.
- The service offered an accreditation scheme for community optometrist.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure all patient records are stored securely at all times.
- The provider should ensure all policies are reviewed and reflect current guidance within agreed timelines.
- The provider should ensure that the safeguarding policy for children references current guidance.
- The provider should consider recording version control on all documents.
- The provider should consider alternative formats for leaflets and website information.
- The provider should consider posters to indicate a chaperone is available.
- The provider should consider reviewing service level agreements in line with best practice.