Optegra Manchester Eye Hospital

Quality Report

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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Overall summary

Optegra Eye Hospital Manchester facilities include; a patient lounge, sub waiting areas with the capacity for 50 patients, six consultation rooms, two treatment rooms, one refractive eye theatre, a refractive patient preparation room, a refractive patient recovery room, a preoperative ward, a post-operative ward, seven diagnostic rooms and one ophthalmic operating theatre.

The hospital provides surgery and outpatient services for adults. The hospital does not offer treatment to under 18 year olds. We inspected surgery and outpatients.

Summary of findings

We inspected this hospital using our comprehensive inspection methodology. We carried out the announced part of the inspection on 19 and 20 July 2017, along with an unannounced visit to the hospital on 28 July 2017.

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

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

The main services provided by this hospital were ophthalmic consultations and diagnostics, disease management and treatment. Treatments included surgical and medical treatments. There were no inpatient stays at this hospital, all patients were treated as day cases and were discharged the same day.

The surgery and outpatient services worked closely together with staff working between disciplines. Where our findings on surgery for example, management arrangements also apply to outpatient services, we do not repeat the information, but cross-refer to the surgery core service.

We rated this service as Requires Improvement overall.

We found areas of good practice in surgery:

- The hospital audited the outcomes of every patient who had surgery at the hospital. The hospital measured outcomes hospital wide and individually for each consultant.
- The hospital proactively forward planned surgical and clinic sessions and used data to identify the number of patients waiting for treatment and procedures. The NHS Family Test (FFT) results reflected this by comments from the patients.
- Patient outcomes survey showed 80% of patients said that they strongly agreed with the statement; I would recommend treatment to family and friends.
- Patients we spoke with stated that their pain was monitored and treated appropriately.
- The needs of diabetic patients were assessed pre-operatively and post-operatively. Staff were aware of the needs of diabetic patients and acted appropriately if the patients blood sugar levels were low.
- The hospital had an eye sciences department, whose role was to collate data on Refractive Lens exchange (RLE), cataract surgery and laser surgery. The eye sciences team collected data for all Optegra hospitals across the UK.
- Regular Medical Advisory Committee (MAC) meetings were held at the hospital where the eye sciences report would be discussed to enable the hospital to bench mark against other Optegra hospitals and other eye hospitals.
- The hospital collected comparative outcomes by clinician and used this for competency and revalidation purposes as well as for quality improvement processes through the MAC and clinical governance processes.
- The hospital provided a 24 hour helpline for advice to patients outside of normal working hours. Consultants were available during normal working hours to review patients if staff felt medical input was required.
- Staff were familiar with the necessary minimum one week cooling off period for certain procedures and we saw that these periods were observed.
- Patients we spoke with said they felt involved in decisions about their care and treatment and that treatment plans were clear and understood. They said that staff took time to involve them and explain things in a way that they understood.
- The services were delivered in pleasant and appropriate premises, with excellent facilities for patients and staff.

We found areas that required improvement in surgery:

- We observed patients being prepared for cataract surgery in the anaesthetic room and then instructed to transfer from the bed and walk into the operating theatre. We observed patients who were disorientated due to sedation, or walking without their glasses. We saw that several patients required support from theatre staff in order to safely make the transfer
- At the unannounced part of the inspection we found that a new standard operating procedure had been

Summary of findings

completed with regards to the safety of patients walking into the operating theatre, we did not receive assurance that this process had been risk assessed and deemed to be safe practice.
- The hospital was not able to evidence individual competency for specific tasks such as the dispensing of medicines to take home, nurse led discharge and pre-operative assessments.
- We found that confirmation of consent for surgery was not shared with the wider surgical team as part of the WHO safer surgery checklist procedures as would be expected.
- The hospital had a World Health Organization (WHO) Surgical Safety Checklist Policy in place. However, upon observing this process we found that the hospital was not compliant with this policy, or the overarching principles of the WHO surgical safety checklist and the National Patient Safety Agency (NPSA) five steps to safer surgery guidance.
- The hospital did not carry out observational or documentation audits of safer surgery safeguards therefore they could not identify staff compliance or highlight areas that needed improvements.
- The duty of candour was not embedded and appropriately applied by senior staff.
- Actions recommended as a result of an investigation identified failings within surgical safety processes, some of the recommendations had still not been implemented in full.

We found good practice in relation to outpatients and diagnostics:

- The hospital managed staffing effectively and services always had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- Consultants and staff told us they believed that they had access to the latest equipment and if new equipment was needed this was readily provided.
- The hospital had a good maintenance scheduled that checked the equipment available and made sure that routine maintenance was in place within the Outpatient Department (OPD).
- Records were comprehensive and contained referral letters and clinic letters that would be needed for any consultation.
- Care was delivered in line with national guidelines.
- Patient safety was maintained throughout. Patients attended a clinical assessment prior to being seen by the consultant, where any patients deemed unsuitable for treatment were identified.
- The hospital supported student nurse placements in order to assist both the development of student nurse skills and their own staff members.
- The hospital offered a range of appointments which meant that patients could attend at times suitable for them. A satellite clinic offered outpatient appointments, so patients did not have to travel as far.
- Patients living with Age Related Macular Degeneration (AMD) were a priority for treatment. This was because that once diagnosed, delays in treatment could be detrimental to patients sight.
- All staff spoken with in OPD told us that they felt very well supported and enjoyed working at the hospital. They told us that there had been recent changes in the leadership but they were confident that the new management team understood the hospital and its staff.

We found areas that required improvement in outpatients and diagnostics:

- The medicines management policy stated that staff needed to dispense medicines using a standard operating procedure. A standard operating procedure was not in place at the time of the inspection, but was being developed. This meant that staff did not have the guidance they needed in order to make sure that they dispensed medicines in a consistently safe manner.
- At the announced part of the inspection we saw that the staff members within the ward were giving out medicines to take home in a manner that did not always maintain the safety of patients.
- Prescriptions concerning eye drops did not contain information regarding the quantity required; therefore staff could not make this decision safely.
- Pain relief was discussed with patients on discharge, however these discussions were not recorded in patients notes in order to determine and record that the best advice and support had been given.
- The hospital had not carried out training and competency assessments around the nurse dispensing of medicines for outpatients which was contrary to the hospital medicines management policy.

Summary of findings

- Discharge information we reviewed did not consistently include relevant information about medicines. Patients were given verbal information, on when and how to take the prescribed medicine. However this was not recorded in the patients records in order to make sure that this information was consistent and fully understood by the patient.
- We observed that there was an inconsistent approach from staff greeting patients. The majority introduced themselves to patients in order to set them at ease others did not.
- Patient information leaflets in different formats such as braille, large print or other languages were not readily available on site.
- The outpatient department displayed their complaints leaflet that informed patients of how to complain. However this was available only in one format and one language.
- The results from the 2017 staff survey highlighted dissatisfaction amongst staff. We were told that this led to an internal review at corporate level followed by major changes in staffing at Manchester eye hospital. A new clinical manager was installed and the Optegra national clinical advisor was consulted to seek improvements.

We found good practice in relation to both surgery and outpatient and diagnostics:

- There were systems in place to keep people safe and safeguarded from harm. The hospital had procedures to investigate and learn from incidents. Staff were confident on how to raise incidents.
- The environment was visibly clean and well presented, procedures were in place to prevent the spread of infection and equipment was well maintained and appropriate for the services provided.
- The hospital was responsive to patients who required additional support, such as patients living with hearing or language difficulties.
- The hospital had robust arrangements in place for obtaining consent for patients having surgery or other procedures at the hospital. The mental capacity of a patient to consent to treatment was reviewed during consultation and the pre-operative assessment stage. For those who did not have capacity, a best interests discussion took place to decide the best course of action for the safety of the patient.
- The hospital received six complaints between May 2016 and April 2017. It had a complaints system process in place and supported patients who had concerns about the service.
- Optegra, which included Optegra Manchester, had achieved number one in category for Trust Pilot. They had been voted by the public as Best in category for eye treatment and rated 9.6 out of 10 based on 1,479 reviews.

We found areas that required improvement in surgery and outpatients and diagnostics:

- The hospital risk register did not show a date for when the risk was expected to be resolved.
- The hospitals staff survey was carried out in December 2016 indicated staff felt unsupported by managers.
- Forty-five percent of staff felt that they did not have job security.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and it should take some actions to help the service improve. We also issued the provider with two requirement notices that affected Optegra Eye Hospital Manchester. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	Surgery and outpatients and diagnostic imaging were the only activities at the hospital. Surgery was the main activity of the hospital. Where our findings relate to both activities, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with outpatients and diagnostic imaging. We rated surgery overall as Requires Improvement, because it required some improvements in safety and being well led, though it was found to be good for effective, caring and responsive.
Outpatients and diagnostic imaging	Good 	Surgery and outpatients and diagnostic imaging were the only activities at the hospital. Surgery was the main activity of the hospital. Where our findings relate to both activities, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with outpatients and diagnostic imaging. We rated outpatients and diagnostic imaging overall as good, because it was safe, caring and responsive, though it was found to be requires improvement in well-led. We did not rate the service for being effective.

Summary of findings

Contents

Requires improvement

Optegra Manchester Eye Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Optegra Manchester Eye Hospital

Optegra Eye Hospital Manchester opened in February 2011 and has subsequently treated both private and NHS ophthalmic adult patients across a full range of sub specialities. The service primarily serves the communities of the Greater Manchester area, North and East Cheshire and East Lancashire for its NHS patients.

Optegra Eye Hospital Manchester is part of a worldwide organisation. The service also has a satellite clinic in Altrincham, Cheshire, which provides clinic only appointments, for refractive lens exchange (RLE) initial consultations.

The service is registered to provide the following regulated activities:

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

The service has a registered manager who has been in post since 2011. The current registered manager is also the director of this service and another Optegra Eye Service.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Caroline Williams and three other CQC inspectors. The inspection team was overseen by Amanda Stanford, Head of Hospital Inspection.

Information about Optegra Manchester Eye Hospital

The service is open Monday to Saturday including evenings and a variety of appointment times and options are available. Normal working hours are Monday 8am to 8pm, Tuesday to Thursday 8am to 6pm, Friday 8am to 8pm and Saturday 8am to 3pm.

During the inspection we visited; consulting rooms, treatment rooms, refractive theatre, refractive patient preparation room, refractive patient recovery room, pre-operative ward, post-operative ward, diagnostic rooms, ophthalmic and operating theatre. We spoke with 27 members of staff including; registered nurses, reception staff, operating department practitioners, and senior managers. We spoke with 11 patients. We also received nine ‘‘tell us about your care’ comment cards which patients had completed prior and during our inspection. During our inspection, we reviewed three sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The hsopital had been inspected on two previous occasions by the CQC, both announced inspections; 25 February 2013 and 10 October 2013 and on both inspections, was found to meet all standards of quality and safety it was inspected against.

Activity (May 2016 to April 2017):

- In the reporting period 1 May 2016 to 30 April 2017 there were 432 refractive intra ocular lens surgery performed, 110 refractive laser eye surgery, 33 refractive laser eye surgery , and 2969 other surgical procedures including vitreous retina procedures (VR).
- 25 Ophthalmologists worked at the service under practising privileges. Optegra Manchester employed 12 registered nurses, five Optometrists and two health care technicians.

In the reporting period between May 2016 and April 2017 the service reported;

- No Never events (see section on incidents)
- Two clinical incidents; one no harm and one low harm
- Six complaints

Summary of this inspection

Services provided at the service under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- Pathology and histology

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?

Requires improvement

We rated safe as Requires Improvement because:

- Staff were not clear on what constitutes a serious incident. We found that incidents were investigated and actions applied, however in the two serious incidents we looked at some of the recommendations had still not been implemented in full.
- We found despite the previous issues with surgical safety processes, the surgical safety processes were still not being undertaken in line with best practice.
- The duty of candour was not embedded and appropriately applied by senior staff. They were aware of being open and honest when things went wrong; however patients involved in the two serious incidents were not informed about mistakes at the earliest opportunity.
- There were systems in place for the safe storage, use and administration of medicines; however, the controlled drugs book was not audited at local level and we found there were some administrative errors.
- We saw good use of personal protective equipment (PPE) on the ward and in the operating theatre. However, we also witnessed poor compliance as none of the staff wore gloves or PPE whilst in the anaesthetic room which led to the operating theatre.
- The hospital had appropriate processes and policies in place to assess patient risk, but we found the staff did not always follow the safety checklist guidance.
- The hospital had a World Health Organization (WHO) Surgical Safety Checklist Policy in place. However, upon observing this process we found that the hospital was not compliant with this policy, or the overarching principles of the WHO surgical safety checklist and the National Patient Safety Agency (NPSA) five steps to safer surgery guidance.
- The hospital did not undertake observational or documentation audits of the safer surgery processes. They therefore could not provide assurance that action was being taken to reduce the risk to patients undergoing surgery.

However;

- Staff understood their responsibilities to raise concerns, to record safely incidents, concerns and near misses and to report them internally and externally.

Summary of this inspection

- Patient records both hardcopy and electronic, were accurate, complete, legible, stored correctly and kept people safe.
- The environment and equipment were visibly clean and maintained to a good standard throughout the hospital.
- Cleaning rotas were in place and audited regularly. We initially found that some of this documentation was unclear, thus making monitoring more difficult. We saw this had been improved by staff during our unannounced inspection.

Are services effective?

Good

We rated effective as good because:

- Patient outcomes were closely monitored and the hospital audited 100% of all surgical performance. This was for the hospital as a whole and the outcomes for each individual surgeon.
- The policies we reviewed cited and included relevant best practice guidance such as National Institute for Health and Care Excellence (NICE) guidance for the treatment of Glaucoma and Macular diseases.
- One hundred percent of staff had received an appraisal within the last 12 months.
- The hospital supported student nurse placements in order to assist both the development of student nurse skills and their own staff members exposure to different practice and views
- Regular team meetings enhanced shared learning and built team collaborative working.
- Processes were in place for obtaining appropriate consent and for assessing patient capacity and making best interest decisions where appropriate
- Patients we spoke with stated that their pain was monitored and treated appropriately.
- Diabetic patients were assessed pre-operatively and post-operatively. Staff we spoke with were aware of the needs of diabetic patients and acted appropriately if the patients blood sugar levels were low.

However:

- Staff were dispensing medicines, the policy outlined that this was an extended nursing role. We found that specific training and assessment of competency to undertake this specific task had not been undertaken.

Are services caring?

Good

We rated caring as good because:

Summary of this inspection

- We saw positive interaction from staff in clinic rooms and waiting areas, consistently throughout the inspection. Staff were kind towards patients, joking and smiling with them and putting their mind at ease.
- Feedback from people who used the service was consistently positive. This was reflected in the NHS Friends and Family test (FFT) scores; 100% of the patients said that they were likely to recommend the service. The response rate was 51% which equated to 132 responses.
- During our observations we saw staff reassuring patients and giving them time to understand the treatment they were due to have.

Are services responsive?

Good

We rated responsive as good because:

- The service had varied and flexible opening times, so patients could access the services at a time that suited them. Staff would make sure that patients got an appointment of their choice, sometimes on the day of referral.
- The service had some consultations and clinics in a satellite clinic to promote easier access to patients living further away from the main site.
- Patients living with Age Related Macular Degeneration (AMD) were a priority for treatment. This was because once diagnosed delays in treatment could be detrimental.
- The service achieved the NHS indicator of 18 weeks referral to consultant led treatment. At the time of our inspection the wait was three to five weeks for NHS patients. Private patients had an average referral to treatment time (RTT) of two to five weeks.
- The service provided pre-planned services only. Therefore they were in full control of the numbers of patients they could accommodate at any given period.
- The service had partnerships with a range of qualified optometrists across the UK; these partners could refer patients for treatment if they found conditions that could benefit from treatment.
- The service recognised people who required additional support to communicate and provided assistance in hearing and translation.

However:

- We were told that the service did not monitor waiting times for individual patients once they arrived for their appointment.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

Summary of this inspection

- The hospital risk register did not show a date for when the risk was expected to be resolved.
- There was a lack of supervision and support for staff and lack of oversight in the management of day to day activities within the outpatients and surgery departments. This was due to an absence of lower tier managers or team supervisors.
- The staff survey indicated that staff felt unsupported and dissatisfied with managers.
- Forty-five percent of staff felt that they did not have job security.
- Optegra values were not embedded in the organisation and the strategy was not well understood by staff.

However:

- There had been recent changes in leadership. Staff told us that they felt optimistic about the future, saw improvements in the way they were supported and were enjoying working in the hospital. They were confident that the new management team understood the service and the staff.
- There was an effective governance framework to support delivery of the strategy and good quality care.
- Staff were clear about their roles and understood what they were accountable for.
- The eye services monitored performance and produced a clinical outcomes report which reviewed complication rates and clinical outcomes data for laser vision correction, RLE and cataract procedures performed at that hospital.
- Optegra, which included Optegra Manchester, had achieved number one in category for Trust Pilot (a website which publishes reviews from customers for online businesses). They had been voted by the public as Best in category for eye treatment and rated 9.6 out of 10 based on 1,479 reviews.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

The main service provided by this hospital was surgery. Where our findings on out patients and diagnostic imaging, for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated safe as requires improvement.

Incidents

- The hospital had a standard operational procedure for managing and reporting incidents, this was an Optegra corporate policy. Incidents were reported via an electronic system which all staff had access to. The staff we spoke with at the time of our inspection knew how to access the system and what incidents they should report.
- The incident policy stated that the hospital was bound by the procedures relating to the 'National Framework for Reporting and Learning from Serious Incidents' and the 'Strategic Executive Information System (STEIS)' as directed by the Department of Health and NHS England and other external reporting requirements.
- The hospital had two serious incidents during the reporting period 31 May 2016 and 30 April 2017; they stated they had no 'never events'. Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations have been implemented by healthcare providers.
- When we reviewed these incidents; one involved a wrong type of lens being implanted and the other involved the incorrect prescription being programmed and delivered by the laser. We found that both were graded incorrectly as low and no harm, they were both 'never events' and as such are considered serious incidents which should be reported to CQC. The hospital did not grade, nor follow up these incidents in line with their own incident reporting policy. Furthermore, we also determined that the patients involved in these two incidents were not informed about mistakes at the earliest opportunity.
- The failure to report an incident to CQC is a breach of the Care Quality Commission (Registration) Regulations 2009 (part 4).
- We reviewed the root cause analysis investigations for these two incidents. We saw that the investigation identified failings within surgical safety processes and actions were recommended to help to prevent similar occurrences. We found that some of those recommendations had still not been implemented in full for example the use of a white board and team briefings. This suggested the organisation did not always learn from incidents or when things went wrong.
- Furthermore, on inspection we found despite the previous issues with surgical safety processes which had contributed to the serious incidents, the surgical safety processes were still not being undertaken in line with best practice.
- The hospital reported 16 incidents in the period 20 July 2016 to 19 July 2017. These involved incidents such as a fall, administration errors, medicine errors and equipment issues. The incident report document did not indicate the level of harm caused by these incidents; however it did show what actions were taken and how learning was shared from these events.

- Issues that may affect clinical effectiveness were discussed at the Medical Advisory Committee (MAC) meetings and the clinical governance meetings. Meetings with various location clinical services manager were undertaken to share learning across branches. Minutes were recorded and shared amongst staff to raise awareness and learning from incidents.
- Safety huddles were conducted daily; important safety issues and incidents were communicated at these meetings to highlight significant concerns or potential safety issues.
- 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.
- We found that managers in the hospital were aware of the duty of candour requirements and had received training and we found that although other staff were less familiar with the legislative requirements, they were aware of the principles of being open and honest with patients.
- The hospital stated they did not experience an incident which fitted the criteria for duty of candour processes, and so had not been obligated to implement duty of candour processes. However, we considered that both of the serious incidents above should have been identified as meeting the criteria of a 'notifiable safety incident', but due to the incorrect grading had not been treated as such. We found that the patient was not informed about the mistake in their treatment until three weeks after it had occurred.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- A clinical quality report was produced quarterly, which summarised performance in key areas, for example; unplanned re-admissions, transfers to other hospitals and infection control. This was shared within the hospital to provide an oversight of results and achievements.
- The report was used to monitor improvements in performance over time and to benchmark with other locations in the organisation

Cleanliness, infection control and hygiene

- During our inspection we found the ward and theatres areas were visibly clean and tidy. Cleaning was undertaken by an external contractor through a service level agreement. We saw that cleaning rotas were in place and that these were audited regularly. However we found that some of this documentation was unclear, thus making monitoring more difficult. We raised this with managers and when we returned for the unannounced inspection the documentation had been improved.
- The hospital had an infection control policy in place and this was accessible to staff. The infection control lead for the hospital was the clinical services manager. Infection prevention and control was classed as a component of mandatory training for clinical staff.
- Infection control audits were undertaken periodically to assess compliance with infection control practices and procedures. A recent audit of the theatres environment found them to be 97% compliant. An action plan was implemented to further improve this and actions were completed.
- Staff appeared to comply with best practice in relation to uniform standards and theatre dress codes.
- There was adequate access to hand gels handwashing sinks on entry to clinical areas and also at the point of care.
- We observed good compliance with hand hygiene and use of personal protective equipment (PPE) used on the ward and in the operating theatre. Hospital audits of hand decontamination found they were 100% compliant.
- We witnessed failure to comply with hospital policy and best practice concerning infection control in the anaesthetic room which led to the operating theatre. None of the staff we witnessed wore gloves or PPE whilst in the anaesthetic room. We observed the cannulation of a patient and the administering of local anaesthetic injections and the cleansing of the surgical site without the use of PPE.
- Furthermore, despite using a 'sterile pack' for cleaning and injecting of the surgical site, staff did not wear gloves and so contaminated the sterile field with their hands. We raised this with the hospital managers and they stated that this had been raised with staff and staff had been reminded that they must comply with the use of PPE and infection control practices.

- We were advised that the hospital had no healthcare associated infections during the period May 2016 to April 2017.

Environment and equipment

- We found that the clinical areas were well maintained, free from clutter and provided a suitable environment for dealing with patients.
- Waste and clinical specimens were handled and disposed of in a way that kept people safe. This included safe sorting, storage, labelling and handling.
- The hospital used single-use, sterile instruments as appropriate. The single use instruments we saw were within their expiry dates. The hospital had arrangements for the sterilisation of reusable instruments which were contracted out and monitored through a service level agreement with an external provider.
- Emergency and resuscitation equipment was accessible in the theatre area. Records indicated that equipment and consumables were checked in line with hospital policy. We checked a sample of consumables and these were in good order and in date.
- The resuscitation trolley was equipped with a defibrillator, oxygen and portable suction and we saw that emergency drugs were stored appropriately in tamper evident bags. It was noted however, that this trolley was not able to be sealed and so not all the items were 'tamper evident', in particular, it would not be evident if fluids had been tampered with. Staff told us that a new fully sealable and tamper evident trolley was on order, which was the same as the one as in the outpatients department, this would rectify this issue. The situation had been risk assessed and it was decided that the first trolley should be placed in the more public area of outpatients and the older trolley remain in the operating theatres which was a more restricted area with less patient throughput.
- The hospital had a range of refractive eye treatments using the following equipment on site LensAR Infinity phaco; Intralase Femto second Schwind excimer; Schwind excimer and Constellation (VR). We were told that manufacturers' instructions were followed for the maintenance of these machines.
- A designated member of staff was responsible for overseeing and ensuring the maintenance, safety checks and servicing of equipment was undertaken effectively and that an accurate asset register was maintained for all equipment in the hospital. We checked a sample of items in the asset register and saw that these had up to date servicing records.
- The traceability for implants used in surgical procedures was maintained by retaining the bar codes with unique traceable reference numbers. These were recorded in patients' medical records. Patients were given a card to keep which contained the barcodes and unique reference numbers for their own lens implants.
- Airflow was maintained in the theatre with 15 changes of air per hour, which was in line with the Royal College of Ophthalmologists ophthalmic services guidance on theatres, the airflow system was tested and serviced annually and we saw evidence of its compliance with required standards.
- The laser room was a large, visibly clean, clinical space with a clinical trolley. The trolley held the laser room checks book and we saw that the room temperature and humidity checks were carried out and dated, timed and signed accordingly. Rooms used for lasers were appropriately equipped, were lockable and had appropriate warning notices and signage.
- Each time the laser was used the temperature and calibration was recorded.
- A laser refractive information booklet was accessible to staff on the clinical trolley. The book included; the safe use of Mitomycin –C, prompt cards for latex allergies, MRSA patient information and management of hypoglycaemia (which is low blood sugar).
- Local rules were displayed in the laser room and we saw that staff had signed the register to confirm they had read and understood the local rules. All signatures were up to date.

Medicines

- The hospital had a medicine management and administration policy in place. This was readily accessible to staff via the organisation's electronic system.
- We saw accurate records were kept when medicines were administered and records included the patient's allergy status.
- The hospital had a service level agreement in place with a pharmacy; this also involved the provision of

medicines management audits by this external contractor. We saw evidence that audits of stock, storage and medicines recording were undertaken at a minimum of three monthly intervals.

- Medicines were stored securely and there were processes to ensure they remained suitable for use. Fridge temperatures were checked and recorded daily to ensure that certain medicines that required refrigeration remained suitable for use and room temperatures were checked by the hospital maintenance staff.
- Staff were aware of the procedures to follow if temperatures became out of range and would contact the pharmacist to confirm drugs remained fit for use should this occur.
- We checked a sample of medicines and found these to be in date. We were advised that the external pharmacy checked expiry dates, stock reconciliations and provided stock top ups. We also found all emergency medicines were in date. The sample of controlled drugs we checked was found to correspond to the details in the register.
- Local audits such as the weekly checks of controlled drugs were being completed and documented however records management checks as described in the Optegra policy were not being completed. We found that there were some administrative errors in the controlled drugs book which would not have been picked up on external audits, but which would have been noted on local checks. We raised this with managers who wrote and implemented a new standard operating procedure ensuring a weekly management check was introduced.
- We saw that nurses were administering some prescription medicines (eye drops) to patients prior to their procedure. We were told that this was done under 'patient group directions' (PGD). This is where a 'group prescription' for a particular medicine is pre-authorised under strict conditions and must follow strict guidance.
- When we checked the PGD we found that contrary to guidance that the PGDs were not signed by a doctor and a pharmacist. We saw that although nurses had signed the document, the authorising signatures were missing in the majority of cases. With regards to the actual prescriptions we found there were no indications (why they were being given) on some and one of the eye drops was instructed to be given immediately prior to treatment when in fact it takes 60 to 90 minutes to become most effective.
- We found that following surgery nurses were dispensing prescribed medicines from the hospital stock supplies. Whilst the Nursing and Midwifery Council gives provision for this practice as being within nurses' scope of practice, he guidelines state that this must be in the course of the business of a hospital, and in accordance with a registered prescriber's written instructions and covered by a standard operating procedure. It also states that the patient has the legal right to expect that the dispensing will be carried out with the same reasonable skill and care that would be expected from a pharmacist.
- During our inspection we found that this was not the case as there was no standard operating procedure in place, and the labelling of the medicines did not describe the total amount of medicine supplied and any additional advice such as 'causes drowsiness'. Therefore nurses were acting outside of their scope of practice.
- We raised these issues with managers and they stated they would implement actions to correct these issues immediately. When we returned for the unannounced part of the inspection, we found that a new standard operational procedure had been implemented and new medicine labels had been introduced.

Records

- We saw that the hospital had both hardcopy and some electronic patient records. The hardcopy files had colour-coded covers to identify which patients were NHS and which were private patients. This was done so that the correct care advice and referrals could be made.
- The electronic records contained copies of information sent to private patients regarding the costs of their treatment in order to provide the patient with relevant information.
- For surgical patients this involved a physical file containing key records such as the WHO surgical safety checklist, medicine administration records, consent forms and pre-operative assessments.
- Patient risks were assessed and documented on pre-op assessment charts. The details were entered into the

computer system, which took the nurse through standard sets of questions and assessments. The results were then printed and placed in the patient notes highlighting relevant aspects for that patient.
- Patient records included information such as the patient's medical history, previous medicines, consultation notes, treatment plans and follow-up notes.
- The records included information specific to the treatment needed such as the recommended type and prescription of lens to be implanted during surgery based on various test readings.
- The serial number of the implanted lens was logged on the patient's records, as was any other equipment used during surgery. This meant there was an audit trail available that if there were any later issues with implants the patient could be tracked.
- The hospital retained all copies of the patient records and supplied patient information as needed to external professionals.
- The patient liaison staff we spoke with told us they made sure records were available for patients who were attending for surgery by checking the ward staff had these records before surgery took place. We confirmed this during the inspection and observed that records were made available as needed throughout the department. The record then went with the patient into surgery so a contemporaneous record of treatment could be maintained.
- We reviewed a total of 18 patient records. The records held details of the patient's full medical history in the hospital, including medicine records, diagnosis and treatment history. We also saw that the records contained observations immediately after surgery in the ward area where patients rested in comfortable chairs.
- Staff told us and records available confirmed that in the three months before the inspection there was no occasion in which patients had received treatment without relevant records.
- The records we checked appeared comprehensive and complete. We noted that the handwriting by some medical staff was barely legible and did not meet best practice standards. Entries were not always timed, dated and stated the author's full name and designation; we found that notes often just contained a doctors initials. Notes by other members of staff appeared to conform to best practice standards.

Safeguarding

- The hospital had a safeguarding policy in place and this was in date, had been reviewed and revised regularly and was accessible to staff.
- The hospital had a separate, on-site, safeguarding lead that was able to provide advice when necessary. There was a national corporate safeguarding lead that was also available to provide advice and oversight.
- Safeguarding vulnerable adults and children was included in the hospital mandatory training programme. Although the hospital did not treat children, they completed child protection training to ensure they were aware to recognise and respond to potential safeguarding issues concerning children associated to their patients.
- At the time of our inspection, we found that 87% of all eligible staff in the hospital had completed safeguarding adults and children training.
- Staff we spoke with were familiar with their obligations regarding safeguarding and knew what they should do if they had concerns about a patient or their family.

Mandatory training

- The hospital had a mandatory training policy. Staff were required to undertake a range of general and role specific mandatory training modules which were both online and in person. This was in line with the policy and the mandatory training schedule, which set out the frequency that each module was to be repeated.
- General subjects included basic life support, safeguarding children and vulnerable adults, the mental capacity act and deprivation of liberty safeguards (DoLS), infection prevention and control, equality and diversity and manual handling
- Mandatory training completion rates across the whole hospital were at 84% at the time of our inspection. The hospital did not set a target for this training.

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

- Managers told us that the hospital did not have a specific admission or exclusion criteria for patients. They stated that they assessed the suitability of each case on its own merits. They stated they generally accepted patients who classed as level 2 or 3 within the American Society of Anaesthesiologists (ASA) Physical Status classification system. However, this was only if

they assessed that they could safely meet their medical needs. This assessment was undertaken through a 'triage' process upon referral, through the outpatient consultation and through pre-operative assessment processes.

- The service did not routinely weigh patients and so did not calculate body mass index (BMI), therefore did not use BMI as an exclusion criteria. As they did not weigh patients, they could not determine if maximum weight restriction for certain pieces of equipment were being observed.
- We were told that due to the fact that the ophthalmic surgery is only conducted under a local anaesthetic and is of short duration, the risk of venous thromboembolism is minimal; however a general risk assessment that might highlight if any precautions might be required is taken as part of the pre-assessment process.
- A staff briefing was held prior to each surgical session. This was attended by all staff involved in the surgery in theatre. The meeting reviewed a brief summary of each patient undergoing surgery and highlighted any specific issues or concerns, such as any notable past medical history or comorbidities, any changes to the theatre list or specific equipment required for a particular case.
- The hospital had a 'World Health Organization (WHO) Surgical Safety Checklist Policy' in place. However, upon observing this process we found that the hospital was not compliant with this policy, or the overarching principles of the WHO surgical safety checklist and the National Patient Safety Agency (NPSA) 'five steps to safer surgery' guidance.
- We observed several departures from WHO and NPSA guidance and the hospital's own policy. Namely; staff did not introduce themselves to each other by name and role at the briefing, they stated that they already knew each other. Later at the 'time out' phase they failed to introduce themselves by name and role again. They also did not record information on a visible wipe clean board as per their policy.
- The 'sign in' phase involving the checking of the patient's allergies, confirmation of consent, surgical site marking and patients' understanding of procedure was conducted in the absence of the surgeon and other team members. This was not in keeping with the WHO principles and was not complaint with the Optegra policy which states that the sign in must be done before induction of any anaesthesia whether that be topical, sedation or general anaesthetic; it also states the consultant must be present at 'sign In'.
- We observed that the 'sign out' procedure was conducted in line with best practice. We were told by staff that debriefs were conducted at the end of lists but did not observe a debrief session during the inspection.
- We were told by managers that the hospital did not carry out any observational or documentation audits of the surgical safety process. Managers stated that they planned to implement an audit programme as part of the review of surgical processes.
- Upon arrival for their procedures the patients were admitted by a nurse. They had their observations recorded, including blood pressure, pulse and oxygen saturations. A temperature was taken if indicated. Patients' known allergies were recorded in their records and they were given a red wristband to alert the surgical team that they had an allergy. Their health and past medical history was reviewed and they were asked if anything had changed since their pre-operative assessment. They were also reviewed by the surgeon and anaesthetist where relevant to ensure they remained were suitable for surgery.
- We observed patients being prepared for cataract surgery in the anaesthetic room. Patients had their glasses removed, eye openers inserted, local anaesthetic injected and the surgery site cleaned with solution. Some patients were also administered sedation medicines. Patients were then instructed to transfer from the bed and walk into the operating theatre. We observed that a patient who had received sedation was very disorientated and unsteady and they stumbled whilst making the transfer. Furthermore we observed that even patients who had not received sedation appeared disorientated having had interference to their eyes, then getting up without glasses. We saw that several patients required support from theatre staff in order to safely make the transfer.
- We raised this issue with managers who stated they would review and risk assess this practice. When we returned for the unannounced part of the inspection we found that a new standard operating procedure had been completed, but there was no risk assessment on this process. The standard operating procedure stated that patient under sedation should receive oxygen therapy and be monitored throughout. Patients we

observed were not monitored by oxygen saturations and pulse, nor did they receive oxygen therapy during the period they remained in the anaesthetic room. This meant the process was not compliant with the procedure in place. We did not receive assurance that this process had been risk assessed and deemed to be safe practice.

- During the surgical procedure within the operating theatre, the patient's pulse rate and oxygen saturations were monitored and displayed on a screen for team members to observe.
- A staff de-briefing session was carried out at the end of each surgical session to share any good practice and highlight any learning which could be shared. Patients who became acutely ill were transferred by ambulance to the nearest NHS acute hospital. This had happened on two occasions in the reporting period 31 May 2016 to 30 April 2017.
- The hospital provided a 24 hour advice line which patients could telephone following their surgery. However, they were advised to seek emergency medical assistance for more serious matters following discharge.
- The hospital had an on-site laser protection supervisor; this individual had received the appropriate training and competency assessments. We found that 83% of eligible staff had completed 'laser safety core of knowledge' training.
- The hospital had an anaphylaxis policy in place with a standard operating procedure of what should be done in the event of an incident; this was readily accessible and familiar to staff.

Nursing and support staffing

- Due to the nature of the service provided and the size of the surgery department, it did not use a formalised staffing acuity tool. The clinical services manager assessed and anticipated the numbers of staff required based on the number and type of procedures that were being undertaken for that session. This information was then used to plan and schedule the appropriate numbers of nursing staff required.
- The clinical service manager was responsible for ensuring an effective mix of skills and ensuring competence of staff was maintained.
- The operating theatre team comprised of a surgeon, a scrub practitioner, a circulating practitioner and a nurse responsible for monitoring the patient. An anaesthetist might also be present if a patient was sedated for the procedure.
- Patients were recovered in the ward area where at least one registered nurse was present.
- Our observations determined that there were satisfactory numbers of staff on duty to maintain patient safety. Staff and patients reported there were sufficient staff available.
- Handovers were conducted as necessary where incoming staff were taking over during the course of a patient's treatment, or there was a need to transfer the care of a patient to another nurse. However, this did not happen very often as most staff worked long days.
- The hospital had its own 'bank' of staff that could be called upon when required. These individuals had experience and knowledge of the hospital and were current or former Optegra staff. The hospital had not used any agency staff in the reporting period 31 May 2016 to 30 April 2017.
- Sickness rates were recorded at hospital level only. The average rate of sickness between May 2016 and April 2017 was 4.6% for nurses, 0.7% for health care technicians and 1.1% for other clinicians.
- The hospital had 0% vacancies for all staff members.

Medical staffing

- The hospital did not directly employ any medical staff but had 25 ophthalmologist consultants who worked across surgery and outpatients under the practising privileges scheme.
- Medical oversight was maintained by the Optegra national medical director from whom advice could be sought on corporate medical matters. Local medical supervision was available from the medical advisory committee chair that through the committee reviewed and monitored clinical practices across the hospital.
- Medical advice was always available for advice and consultation during opening hours. Input from the patient's own consultant was available by telephone if needed. Cover was provided by another consultant with the same sub speciality for any period of absence or leave by individual consultants.
- We saw evidence that a robust process operated for the granting of practising privileges. All appropriate checks

such as disclosure and barring service (DBS), General Medical Council (GMC) and specialist registration and health screening were carried out before practising privileges were granted.
- Although the service did not accept emergencies, a consultant or doctor was available during usual opening hours to review patients who might be experiencing difficulties post-operatively.

Emergency awareness and training

- A business continuity plan was in place which covered potential risks such as dealing with crisis event management, bomb threats, IT system and hardware failures, clinical equipment failure, utilities failure. A risk management policy was also in place covering non-clinical risks, such as fire etc.
- Staff had received fire safety training as part of the mandatory training package.
- Evacuation procedures were in place and emergency simulation exercises were practised periodically.
- The hospital had recently undertaken a practise cardiac arrest exercise to check that the processes were effective and embedded for staff.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- The hospital followed national guidance and best practice by the Royal College of Ophthalmologists and National Institute For Health and Clinical Excellence (NICE) in relation to patient care pathways, cataract, medical retina, glaucoma, cornea and vitreoretinal procedures.
- The clinical services manager in conjunction with the clinical governance committee was responsible for ensuring that the hospital was kept up to date and aware of how new guidance affected clinical practice.
- The hospital had a comprehensive range of local policies and procedures. These were reviewed and updated regularly and reflected current best practice and evidence based guidance. However, we found evidence that the hospital was not compliant with elements of their own internal and corporate policies such as medicines management in relation to the dispensing of medicines on discharge and patient group directions. We also found they failed to adhere to some elements of their WHO surgical safety policy and infection control policy. See relevant sections above.
- The hospital participated in some local and corporate audits, which were used to benchmark performance against other Optegra hospitals nationally and internationally.

Pain relief

- Pain relief was administered in the form of anaesthetic eye drops prior to surgery or procedures. Patients were asked about pain levels during and after procedures.
- Staff could seek advice and input from surgeons where patients complained of pain after surgery in the recovery area.
- Patients were advised on pain relief during discharge discussions and advised on recovering at home. They were given a 24 hour helpline number but we told if the pain was severe they should go to their local accident and emergency department.
- Patients we spoke with stated that their pain was monitored and treated appropriately.

Nutrition and hydration

- Due to the nature of the surgical services offered, there were no specific nutritional or hydration facilities in place. However, nursing staff offered drinks and snacks to patients pre and post operatively.
- The needs of diabetic patients was assessed pre-operatively and post-operatively. If they were insulin dependent and required to fast for a procedure, for example if they were receiving sedation, the consultant or anaesthetist was able to advise on the number of units of insulin they should take beforehand in order to help prevent a drop in blood sugar levels.
- Staff we spoke with were aware of the needs of diabetic patients and would offer appropriate snacks or drinks to patients if their blood sugar levels were low.

Patient outcomes

- We spoke to the head of Eye sciences, whose role was to collate data on Refractive Lens exchange (RLE), cataract surgery and laser surgery. The eye sciences team collected data for all Optegra hospitals each quarter and presented the data across the UK. Data collected would include operative details; pre-operative, post-operative

and clinical outcomes. For example the results showed Optegra Manchester scored 100% for the number of treatments undertaken and the percentage of treatments with no recorded operative complications over the past four quarters, compared to 99% in the rest of the UK Optegra hospitals.

- The Medical Advisory Committee (MAC) meeting held at Optegra Manchester would receive the eye sciences report to enable them to bench mark against other Optegra hospitals and other eye hospitals. Numbers of procedures each month are monitored and outliers checked.
- Eye Sciences have recently started to audit the Optegra hospitals outside the UK, which include Poland, China and Germany. Bi-weekly calls are held to share information nationally.

Competent staff

- Any new doctor applying to work at the hospital would be discussed at the MAC. They would look at the practicing rights and background to consider their suitability. They would ensure that the doctor's appraisal was up to date and if their skill was required at the hospital.
- All new staff completed an induction programme on the internet, which included; health and safety, access to systems, mandatory training, human resources and policies and procedures. Staff would have a six month probationary period.
- An informative induction booklet was issued to new staff which informed them of; the fire evacuation procedures, emergency contingencies, local contact numbers, health and safety policy statements and contractor rules.
- Any new procedures brought to the hospital by doctors were also discussed at the MAC and if considered, they then had to be signed off by the medical director, as safe to be used.
- If a doctor had not practised at the hospital for 12 months or more the MAC would consider removing them from the list.
- The registered manager ensured that consultant surgeons and other staff from the NHS working at the hospital had practising privileges. We reviewed five personal files of surgeons and all checks were in order. These included, amongst others; practicing privileges interview forms, ophthalmic surgery certificates and disclosure and barring service (DBS) checks.
- The hospital collected comparative outcomes by clinician and used this for competency and revalidation purposes as well as for quality improvement processes through the MAC and clinical governance processes.
- The hospital's annual appraisal programme ran from July to July each year, as our visit was undertaken in July 2017 we found that the annual appraisals for 2017 were 'due' for completion. During the inspection we saw that 100% of staff had received an appraisal within the last 12 months from July 2016 to July 2017.
- The clinical services manager had a system for identifying which staff were competent to work in which areas of the hospital, such as those who could act as scrub nurse, co-ordinator or undertake cannulation, IV administration etc. However, was not able to evidence individual competency for specific tasks such as the dispensing of medicines to take home, nurse led discharging and pre-operative assessments which may be considered as extended practices for nurses.
- This meant that there was a lack of assurance that nurses were competent to perform these roles. We spoke to managers about this on inspection and they advised us they would be working on a new system to evidence these as a priority in the coming months.

Multidisciplinary working

- During our inspection we saw good multidisciplinary teamwork between disciplines within the hospital. There appeared to be a sense of respect and recognition of the value and input of all team members.
- A number of staff were able to work across the hospital covering surgery and outpatients duties. This meant that staff were able to demonstrate an understanding of different roles and better collaboration with colleagues. In turn, this led to continuity for patients on longer-term treatment pathways.
- Within theatres staff stated that teams worked well together and all members of the team had a voice. Staff said that all grades of staff were able to have their opinions heard.
- The hospital had effective external working relationships through service level agreements with external contractors to facilitate the effective running of the hospital. This included the provision of pharmacy services, clinical waste management and disposal, laundry, cleaning and estates management.

- The hospital had effective relationships with community eye practitioners such as optometrists, opticians and community nurses.

Access to information

- Patient records were both electronic and paper based. All staff had access to full details of a patient's past medical history, medicines, allergies, referral letters, consent information, clinic notes, pre-assessment notes, and consultants' operation notes.
- Paper records were kept on site for three months before being archived to an external storage facility. Documents could be recalled should they be needed after being archived.
- Staff had access to the information required to undertake their role. They had access to a range of policies, standard operating procedures and open source material via the computer system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A corporate consent policy was in place at the hospital. The policy was compliant with Mental Capacity Act and Deprivation of Liberty Safeguards legislation. The policy set out staff responsibilities for seeking and obtaining informed consent, including the type of consent (verbal or written) needed for different procedures undertaken at the hospital.
- Training on Mental Capacity Act and Deprivation of Liberty Safeguards legislation formed part of the safeguarding vulnerable person's mandatory training module.
- The hospital had never had cause to seek a deprivation of liberty authorisation.
- The responsibility for consent to procedures was undertaken by consultants, this took place at consultation or immediately prior to the procedure. All patient records we looked at had completed and signed consent forms.
- We found that confirmation of consent for surgery was not shared with the wider surgical team as part of the WHO safer surgery checklist procedures as would be expected.
- The capacity of a person to consent to treatment was reviewed by consultants and staff nurses during consultation and the pre-operative assessment stage. For those patients who lacked capacity a decision was made whether their needs could be accommodated based on the type of treatment they sought. For some, the hospital acknowledged a general anaesthetic was necessary which could not be accommodated at this hospital, therefore they were referred back to the NHS acute service.
- We saw evidence of consideration of the capacity of a patient and their consent for treatment. We saw that appropriate actions were taken; best interest decisions were made with input of the family and healthcare professionals, a consent form four was completed together and evidence of the power of attorney for health issues was obtained.
- For certain elective procedures such as some of those being undertaken at this hospital, best practice guidance suggests that practitioners should allow a minimum of one week between the date of consultation where they agreed to a procedure and the date the procedure is undertaken. This allows the patient a 'cooling off' period during which they can consider their decision and change their mind if they wish to. The staff we spoke with were familiar with cooling off periods and we saw that minimum cooling off periods of at least one week were observed.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- All staff, including reception staff and non-clinical staff, were highly compassionate and respectful to every patient who used the service.
- We witnessed that the privacy and dignity of patients was maintained at all times.
- The NHS Friends and Family test (FFT) results reflected this by comments from the patients; 100% of the patients said that they were extremely likely to recommend the service. The England average being 94%. The response rate was 51% which equated to 132 responses.
- One additional comment made by a patient in the free text box on the FFT was 'I was treated in a kind and caring way and (this) made me feel less anxious'.

- We spoke to 11 patients and their families during our visit and all patients we spoke to, spoke positively about their care; 'Excellent', 'Very, very, good' and a number of patients said the service was fantastic and there was nothing they would change.
- Out of the 11 comment cards we viewed from patients, nine spoke positively with regards to the care they had received. One patient wrote; 'All staff's attitude and care are of the highest standard.' One family member made comment about the 'compassion' shown to her and her father by the patient liaison staff member.

Understanding and involvement of patients and those close to them

- Patients we spoke with said they felt involved in decisions about their care and treatment and that treatment plans were clear and understood. They said that staff took time to involve them and explain things in a way that they understood.
- Consultants ensured that patients had realistic expectations of their procedure and treatment before consent was obtained. Patients were afforded 'cooling off' periods to ensure that they had fully understood and considered all the information available.
- During surgical procedures staff explained what was happening during each stage of the procedure and checked on the patient's welfare.
- Staff ensured that patients had the support they needed following a procedure and involved those close to patients to ensure they were supported when they returned home.
- We observed staff taking time to explain follow up care and instructions to patients and to answer their questions following surgery. This included how to correctly insert eye-drops at home, they also advised on take home medicine details and after-care such as bathing and cleaning the eye.

Emotional support

- Staff demonstrated empathy and understanding about the emotional impact that sight problems might have on patients. They provided emotional support to patients and would refer them to sight support organisations and charities if they felt the patient would benefit from this.
- Staff provided reassurance to patients who were undergoing procedures. They supported nervous or anxious patients by putting them at ease and calmly explained the procedure. They identified patients who might be nervous during pre-operative assessments and considered if they might benefit from sedation.

Are surgery services responsive?

Good

We rated responsive as good**.**

Service planning and delivery to meet the needs of local people

- The services were delivered in pleasant and appropriate premises, with excellent facilities for patients and staff.
- The hospital assessed the requirements of their private and insured patients, the requirements of the local clinical commissioning groups and their potential patients when designing, furnishing and equipping the premises. The needs of all groups were taken into account when planning and arranging the hospital's services.
- Managers told us that the hospital did not have a specific admission or exclusion criteria for patients. They were also unclear about the nature of their agreement with the clinical commissioning groups about which patients they could not accept. They stated they were unable to accept some patients living with dementia or learning disabilities as they could not safely accommodate their needs but this was not formalised into a contract or policy. They could not provide details of the number of patients they had deemed unsuitable for treatment due to the hospital being unable to meet their needs.
- The service provided pre-planned services only. Therefore they were in full control of the numbers of patients they could accommodate at any given period. The service proactively forward planned surgical and clinic sessions and used data to identify number of patients waiting for treatment and procedures.
- They had the ability to decrease or increase the number of surgical sessions and clinical appointments required to meet the needs of patients and to maintain flexibility at busy periods.

- If a surgeon had planned time off then theatre list would not be compiled for those days and in turn if increased numbers of patients were waiting extra sessions could be organised.
- The hospital was planning to open its second operating theatre; this was to ease demands for the current operating theatre. The utilisation of the theatre was oversubscribed and very much in demand during some theatre sessions and was in response to requests by consultants. There was no planned date for the opening of the second operating theatre.
- The second theatre would enable the hospital to accommodate more surgical sessions, reduce waiting times, in particular waiting times for private patients and treat greater numbers of patients generally.
- The hospital was open from Monday to Friday between 8am and 8pm and on Saturday between 8am and 3pm.
- The service provided a 24 hour helpline for advice to patients outside of normal working hours. Consultants were available during normal working hours to review patients if staff felt medical input was required.

Access and flow

- Patients were able to access the service via a range of means. Self-paying and insured patients were able to self-refer without a GP or optician's referral. Four local NHS clinical commissioning groups (CCG) commissioned services from the hospital for appropriate NHS patients.
- As part of the quality data required by NHS contracts the hospital was required to meet the 18 week Referral to treatment (RTT) pathway. The hospital had no breaches of this requirement.
- During the period 31 May 2016 to 30 April 2017, the average NHS RTT was three to five weeks and appointments were offered to fit around patient choice and availability. We were told this was achievable as the service offered all diagnostics at the time of the initial consultant appointment and also because they treated under local anaesthetic as a day case.
- Private patients, who include those on the refractive treatment pathways for laser, had an average RTT of two to five weeks subject to laser and refractive consultant availability. All patient treatment is scheduled in the same way regardless of being NHS or private patient and medically urgent patients, are treated as soon as possible as a priority.
- NHS patients followed the NHS patient pathway which included an assessment of suitability and triage by a clinician. These patients required a GP or optometrist referral. For some procedures NHS patients could choose this service through the NHS e-referral programme (formally known a 'choose and book'). Optegra Manchester had also supported two local CCG's with waiting list initiatives, enabling NHS patients to be seen in timely manner.
- Private patients could arrange a free no obligation consultation with ophthalmologists to discuss potential treatments and procedures. They could also attend 'open evenings' where consultants gave a presentation and discussed the various treatments on offer.
- Patients were offered a choice of appointments to suit their circumstances. The hospital was open until 8pm during weekdays and opened on a Saturday until 4pm.
- The hospital had partnerships with a range of qualified optometrists across the UK; these partners could refer patients for treatment if they found conditions that could benefit from treatment.

Patient flow

- The hospital did not provide an emergency eye surgery service. They provided for elective and pre-planned procedures only. Any emergency cases were referred to the appropriate emergency eye care services.
- Discharges following surgery were undertaken by nurses following assessments of the patient's recovery and fitness to go home. If nurses had any concerns they could seek a review by the surgeon involved.
- Discharge letters were completed and copies were sent to the patient's GP and or optometrist/optician, with a copy being supplied to the patient. This letter outlined; the procedure that had been completed, their prescription and details of any treatment plan or post-operative care and follow up.
- Patients were advised regarding post-operative care, how to use the medicines provided and given details of the 24 hour helpline should they have concerns following discharge.
- Follow up appointments were arranged as outpatients at clinic for reviews and dressing changes.
- The hospital cancelled seven operations during the period 20 July 2016 to 19 July 2017. This was due to a

theatre list being arranged when the surgeon was on leave. The patients all had their procedure rescheduled within 28 days and most were rearranged for the following day.

Meeting people's individual needs

- The hospital provided surgery for both private and NHS patients and the patient mix for the last 12 months was 65% NHS patients and 35% privately funded. From what we observed, both patients were treated equally.
- There were no special considerations for bariatric patients and as patients were not routinely weighed, they did not have a system in place to ensure that the operating tables were adequate. We spoke to the management team and it was not something the hospital had considered.
- Patient language and interpretation needs were covered in the hospital's policy on Equality, inclusion and human rights. Staff could access language and interpretation services and information could be made available in appropriate formats. The policy had information for staff for using interpretation services.
- A loop system was in place for hearing aid users.
- The hospital was accessible for those patients with mobility problems and wheel chair users. There were designated disabled car parking spaces and step free access to the hospital. There were designated disabled bathroom facilities on site.
- Optegra's information pack which was sent out to individuals prior to coming in for a procedure was of a small print. We were told that this was not available in a large print, or in another format, e.g. audio. We raised this with the management team as we felt that in particular pre-operative patients would struggle to read this information, management agreed and spoke of improving the packs.
- If patients were found to be particularly worried or concerned at initial consultation or pre-operation stage then the hospital would invite them for a trial visit. This would comprise of the patient walking through the pathway, including getting on and off the trolley, which helped if their concerns were due to mobility issues. The hospital found this extremely helpful and believed they may lose worried patients if they did not invite patients for this extra visit.
- The hospital combined online learning with workshops to discuss key issues and share learning with regards to dementia awareness and safeguarding vulnerable adults.
- Following surgery patients were provided with written information explaining follow-up care. The patients were given contact details of who to call if they had any concerns. Patients were also offered a follow-up appointment the day after surgery to check on their progress.

Learning from complaints and concerns

- The hospital had a complaints policy in place, this was in date, reviewed and updated regularly and was accessible to staff.
- We looked at the hospital's complaints tracker which showed they had received six complaints between May 2016 and April 2017. We found that all of the complaints had been acknowledged within Optegra's stated time of two working days. A written response following an investigation was evident and the patient informed within 20 working days of receiving the compliant.
- Only two of the complaints out of the six had been closed. The oldest complaint on the tracker still active was for January 2016; however we saw evidence that the patient had been kept informed.
- The process at the hospital was to refer any complaints to the director of the hospital, who would review and escalate to the operations director if they could not resolve it.
- Details of complaints were shared within the governance structure at the Medical Advisory Committee (MAC) and integrated governance meetings. Informal complaints were shared at the daily huddle.
- A patient was advised that they may refer their complaint to the independent sector complaints Adjudication service (ISCAS) for an independent review. Details of how to do this were in the Optegra 'Feedback, comments & complaints' booklet.

Are surgery services well-led?

Requires improvement

We rated well-led as Requires Improvement.

Requires improvement

Surgery

Leadership / culture of service related to this core service

- There had been recent changes in the management team and an interim clinical manager and a new hospital manager had been appointed. They were very positive about the future. Likewise staff we spoke with were optimistic about the new management structure.
- The management team were introducing a team leader for surgery which was welcomed by staff.
- Feedback from staff members produced a mixed picture. Some staff members felt supported, described a good work/life balance and being valued. Whereas others reported they had no received support they deserved over the last 12 months.
- The hospital had an Equality, inclusion and human rights policy in place. The policy outlined that every manager employed by Optegra was responsible for promoting equality inclusion and human rights in their sphere of management and for preventing undue discrimination in practice. The policy had clear aims and objectives.

Vision and strategy for this core service

- Optegra's vision was 'To ensure Optegra UK is a market leading profitable provider of first choice, famous for Patient service and eye care excellence because we look after our colleagues, who look after our Patients'. The values were found on the website, but not displayed around the hospital.
- One member of staff we spoke to could not recite the values but knew where to access them on the intranet.
- The Hospital director said that the vision for Optegra Manchester was to continue with outstanding patient care and all the staff were aware that this was the hospital's priority.

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

- The hospital held Clinical service managers (CSM) meetings quarterly, which were attended by UK clinical lead and head of clinical governance and risk, together with all CSM's from UK Optegra hospitals. Key areas discussed were; medicine management, infection, control, safe guarding, clinical incidents and health and safety. Incidents are shared between Optegra hospitals for learning. The CSM meetings ensured commonality across the hospitals, shared pathways, documentation and encourages staff recognition of their relationship with Optegra. We looked at four sets of minutes from the CSM meeting to evidence the shared learning.
- The service carried out a number of audits, however we saw no evidence of staff members monitoring compliance of the WHO surgical safety check list, or making observational checks to ensure the safety of patients.
- We identified a number of concerns in relation to; poor staff adherence to the WHO surgical safety checklist guidelines, lack of policies and staff competencies around dispensing and labelling of medicines, poor understanding by staff of incident grading and reporting of serious incidents and never events. Therefore we were not reassured that risk management and quality monitoring was robust
- The hospital's 2017 staff survey indicated that staff lacked confidence in the management and their ability to implement changes.
- Eye sciences did not bench mark outside Optegra, but looked at and consider international data and reviewed published papers reflecting outcomes for cataract procedures.
- The risk register accurately reflected all the risks within the hospital. The risk register described the cause and consequence of this risk. We saw from the risk register that the type of risks were categorised as; Financial, quality or operational.
- However, the risk register did not show a date for when the risk was expected to be resolved. We were told that the risk register was under review and they were looking at making the risk register more 'reader friendly' and whether the risk was still ongoing, would be clearer.
- An Integrated governance steering group was held quarterly and attended by Optegra UK senior management team, including hospital Directors, function heads, eye Sciences, Medical director and Optegra UK Managing Director. At the meetings the outputs from the hospital level governance groups were reviewed to ensure consistency, monitor trends and adherence to policy and outcomes data, complaints and serious incidents were also reviewed. We saw evidence of this by reviewing the minutes to the last three meetings.
- A Medical Advisory Committee (MAC) was held four times a year and attended by the chair, an optometrist, clinical nurse, consultant and a spread of

sub-specialities for glaucoma, refractive eye surgery, cataract, cornea and retinal. We looked at the minutes of the last three meetings, which showed they were well attended.

- At the MAC safety issues, adverse events, infections, complaints and incidents were discussed and learning taken from critical incidents and events. Local and National incidents were discussed at the meeting. If a member of staff could not attend the meeting, the minutes would be distributed for their attention.

Public and staff engagement

- The service had a website where full information could be obtained about the treatments available for patients. It was very comprehensive including information about costs and finance.
- Optegra, which included Optegra Manchester, had achieved number one in category for 'Trustpilot' (a website which publishes reviews from customers for online businesses). They had been voted by the public as 'Best in category' for eye treatment and rated 9.6 out of 10 based on 1,479 reviews. We had sight of the comments made regarding Optegra Manchester, which included comments such as; "I would not hesitate to recommend Optegra". "A relaxing and comfortable experience". First class premises, first class facilities, first class staff."
- The hospital used the NHS Friends and family test to find out the views of patients who used the service. How many surveys sent out to patients varied; between February and April 2016, 90 surveys were sent out with a response rate of 59%. Between January and February 2017, 66 surveys were sent out to patients, with a 61% response rate.
- The hospital's staff survey in December 2016 highlighted dissatisfaction amongst staff. Approximately 56% of clinical staff stated that they strongly disagreed with statements such as; their line managers were available when needed, consulted them about decisions that would affect them and that the manager made it priority to spend 1:1 time with them. However, 69% felt there was a strong sense of belonging in their team.
- Forty-five percent of staff felt that they did not have job security. 50% of clinical staff & 40% of managers disagreed that there was a 'no blame culture' and that people felt free to speak their mind.
- Fifty percent of patient services staff and 62% of managers said they had not attended a communication meeting.
- We raised the issues from the staff survey with the management team, concerning the poor figures on management related questions. As a result of the figures Optegra carried out an internal review, after which major changes in staffing were carried out. The clinical manager was replaced with a clinical manager from another Optegra branch and the UK clinical advisor brought in.
- Two years ago the Eye sciences developed a patient questionnaire for those who had undergone cataract surgery, laser vision correction or, refractive lens exchange at Optegra. The questionnaire was developed to be delivered by a touch screen tablet with the guidance of the patient liaison, or a paper version was available.
- We looked at the electronic patient reported outcomes survey for the recording period of June 2014 to June 2017. 499 cataract patients responded to the survey and 80% of patients said that they strongly agreed with the statement; 'I would recommend treatment to family and friends". 40 RLE patients completed the survey and 80% of patients said they strongly agreed with the statement "I feel my quality of life has improved following treatment". Only five respondents were patients who had received laser vision correction.
- Staff 'Huddles' took place daily at 10am where representatives of all departments were present. Staff were informed of who the lead was in theatre that day, visitors to the hospital, rolls and responsibilities of staff and other relevant information that needed sharing.
- Optegra had a staff recognition scheme whereby staff could nominate individuals and teams. In December 2016 the clinical team at Optegra Manchester had been nominated for 'Colleague Recognition' for outstanding commitment and professionalism to their work with colleagues and patients. An individual was also nominated in March 2017 having been new to the company the employee was nominated for taking on extra responsibilities in such a short time frame.
- The hospital held open evenings periodically when the public were invited to view the facilities and ask any questions regarding the process and procedures.
- The Optegra website advertised a free no obligation quote, to test the patient's suitability for Refractive eye surgery. This was only available to private patients.

Requires improvement

Surgery

- The clinical manager had recently left and the new manager had been brought in from head office and was keen to boost morale amongst the staff. A strategy day had been arranged for all the staff to attend and was due to be primarily a social and team building event.
- There was also a change in director at the hospital and the new director due to take over had already booked in new monthly, senior management team meetings, for Monday lunch times, to be attended by the patient services manager, lead ophthalmologist and clinical manager in order to share information and learning.
- There was currently no patient forum in place at the hospital. Patient forums are usually open to any patient or relative to discuss any concerns or anxieties they may have about the hospital and treatment. We spoke to the management team who said this was something they intended to start and planned for these to take place every three months.
- The hospital was actively involved in two local charities and certificates of the fund raising totals were displayed on the walls of the manager's office.

Innovation, improvement and sustainability

- The hospital was interested in further expansion and had recently secured a contract with a local NHS trust for taking all newly diagnosed age related macular degeneration glaucoma (AMD) patients. This means a rapidly growing cohort of patients and the hospital director told us this was the right pathway for the future of the hospital.
- A new monthly hospital-wide meeting had recently been put in place. The meeting was to discuss any relevant clinical governance issues and was to be attended by all staff.
- The management team told us that they would like to reconfigure the hospital waiting room. Currently all patients sit together in one central area, until called through. They planned to segregate areas for patients to make it clear to staff which patients are for which appointments and procedures. They also believed this would be beneficial for patients to sit with similar patients.
- Improvement on waiting times was on the management team's agenda for future improvements. For example, current waiting times for private patients from consultation to operation were 12 weeks and the opening of a second theatre would improve this.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as Safe as good.

Incidents

- The service had a policy for incident reporting and investigation. We reviewed the policy and saw that it identified what to report as an incident and encouraged staff to report accidents or near misses related to safety concerns and practice.
- All staff spoken with in the Outpatient Department (OPD) told us they were supported to raise any potential risks or concerns. They were confident that they were made aware of how to raise incidents. Staff also told us they were informed of learning as a result of incident investigations that assisted in improving the services performance.
- Information provided to us by the service showed that there were no Never Events in relation to OPD reported in either the Manchester or the Altrincham site in the last year.
- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Records available recorded that there were few incidents reported in OPD as such there were no clear patterns that could have identified areas of improvement for the service to monitor.
- Staff working in the OPD told us that daily huddles (small meetings for staff on duty) were in place and at these any new learning was discussed. They told us that they found this useful in order to make sure that they were kept up to date with any changes. Additionally incidents and learning outcomes were discussed at staff meetings.
- We were shown copies of emails that staff had received in relation to safety alerts produced from external organisations. Staff told us that they were kept up to date by Optegra when alerts were made about the latest safety findings. We were also informed by staff that these were discussed at team meetings and they found this information of use.
- Staff we spoke with understood their responsibilities regarding duty of candour. The duty of candour requires staff to be open and transparent with people about the care and treatment they receive. There had been no incidents in relation to OPD that required a duty of candour response.

Cleanliness, infection control and hygiene

- On reviewing the environment we saw that all areas were visibly clean. Protective equipment to assist in the reduction of the spread of infection such as gloves were available and observed to be used appropriately. All bins were hands free or pedal bins, soap in bathrooms was liquid soap and there was access throughout the service to hand sanitiser. These aspects were in place to assist in the prevention of the spread of infection via touch. Additionally the service provided training on hand hygiene and audits took place to ensure that staff adhered to the best practice guidelines of hand hygiene.

- We observed staff practice throughout the inspection and saw that staff washed their hands appropriately and used protective equipment as needed. Staff practice assisted in reducing any risks of the spread of infection within the service.
- Throughout the service we observed that there were "sharps" boxes these were used for the safe disposal of items such as used needles and denatured (destroyed) controlled drugs as needed. The service had a contract with an external organisation for the removal and replacement of sharps boxes in order to make sure that these were safely dealt with.
- All furniture throughout the service at both sites was observed to be easily cleaned. We were shown copies of cleaning schedules available in some areas, such as bathrooms, which recorded that these areas were checked throughout their usage in order to maintain their cleanliness.
- Throughout the inspection we observed the cleaning team attended to any spills rapidly. Patients and their relatives were complimentary about the cleanliness they observed within the service. One person told us "the environment was clean and safe", another said "I like how clean and fresh it looks".
- We looked at the infection, prevention and control policy dated January 2015, this included information on staff training and the disposal of clinical waste to support staff in maintaining good hygiene.
- The policy was supported by a senior staff member who had an additional lead role as infection, prevention and control. Staff members spoken with were aware of who to access for advice regarding any infection control questions they may have.

Environment and equipment

- The service had two sites; in Manchester and a smaller clinic in Altrincham. We saw that both buildings were accessible to patients and their relatives. We looked at clinical areas in both sites including examination rooms, consultation rooms and the area described as the ward at the Manchester site. They were observed to contain equipment that was suitable to the diagnosis, treatment and recovery of patients. Consultants and staff told us they believed that they had access to the latest equipment and if new equipment was needed this was readily provided.
- Records available indicated that the service had an ongoing maintenance schedule that checked the equipment available and made sure that routine maintenance was in place within the OPD. Any equipment or areas of the environment that needed to be repaired or replaced was actioned rapidly in order to maintain the safety of patients.
- We checked the resuscitation trolley located on the main corridor outside the theatre area. The trolley was available for both theatre staff and the OPD area staff. Daily checks were observed to be in place to make sure that all equipment was within expiry date and tested that it functioned safely.
- Emergency medicines were available on the resuscitation trolley were stored within an anti-tamper bag and checked that they remained within their expiry date.

Medicines

- We saw that medicines were stored appropriately in OPD within lockable cupboards to prevent inappropriate access. The service has identified that one area of storage presented a risk to staff consistently having to bend to retrieve the medicines and had made arrangements to relocate the medicines safely.
- Patient records examined recorded patients current medicines, any allergies and a medical history were determined in order to make sure that any medicines prescribed by the consultants were safe to be given and would not react with the patients regular medicines.
- At the announced inspection we saw that staff within the ward were giving out medicines to take home in a manner that did not always maintain the safety of patients. This was because medicines given to the patients did not include vital information they needed such as cautionary labels such as "may cause drowsiness" were not used.
- Staff told us that they had in the past recognised that one bottle of a certain eye drops was not sufficient for patients and gave them two. However when we reviewed the prescriptions we saw that they did not contain the information that staff needed to make this decision safely.
- A copy of the medicines management policy was reviewed. However this did not explore the arrangements in place to support staff to dispense medicines for patients to take home. The policy also stated that staff needed to dispense medicines using a standard operating procedure. We spoke to senior management and nursing staff who confirmed that a

standard operating procedure was being developed and was not in place. This meant that staff did not have the guidance they needed in order to make sure that they dispensed medicines in a consistently safe manner.
- On our return to the service for the unannounced part of the inspection we saw that the service had taken action to reduce some of the risks and had put into place the guidance that staff needed to assist them in giving medicines safely.
- The service did not carry out its own audits for medicines but had contracted for an external pharmacy to do this. The audit system had not identified the issues we found during our inspection.
- For our detailed findings on medicines for this core service, please see the Safe section in the Surgery report.

Records

- The electronic records available contained copies of information sent to private patients regarding the costs of their treatment in order to provide the patient with relevant information before they agreed to the treatment.
- The patient liaison staff we spoke with told us that they made sure that for each pre and post-operative treatment patient records were available for the consultants and returned to a secure storage when the consultants finished their consultation.
- Records reviewed contained copies of any referral letters and clinic letters that would be needed for any consultation. Additionally there were copies of post treatment letters that were sent on behalf of patients to other relevant medical professionals.
- For our detailed findings on Records for this core service please see the Safe section in the Surgery report.

Safeguarding

- Staff told us and records confirmed that OPD staff did not raise or escalate any safeguarding concerns in the previous 12 months.
- Information from the service showed that they do not treat patients under the age of 18 years old. As such the OPD had limited contact with young people. Staff members told us that they were provided with online safeguarding training for both adults and children. They provided child safeguarding training as children can attend waiting areas with their relatives.
- Records showed that all staff with the OPD (100%) in the service had completed safeguarding adults training as part of their ongoing development.
- We saw that there were local and national safeguarding policies and procedures in place, which staff in the service knew how to access and were able to give examples as to what a potential safeguarding concern could be and how it would be dealt with.
- Staff told us that they had access to safeguarding support when required from a senior member of the management team who was allocated as the safeguarding lead. Senior management confirmed that they had a safeguarding lead available within the service that supported staff with any concerns.
- For our detailed findings on safeguarding for this core service, please see the Safe section in the Surgery report.

Mandatory training

- All staff in OPD we spoke with told us that they had had completed their mandatory training before the inspection, this included fire, manual handling, safeguarding training and health and safety. This training was done on line. They also told us they had completed additional training in areas such as dementia care and mental capacity. All staff we spoke with told us that they had particularly enjoyed the dementia care training. Records available with the service showed that staff had completed mandatory training.
- All staff in OPD we spoke with told us that they had life support training at immediate life support level (ILS) or above records available confirmed that 100% of staff had received training in this area.
- For our detailed findings on mandatory training for this core service, please see the Safe section in the Surgery report.

Nursing staffing

- Managers spoken with told us that the service did not use a recognised patient acuity tool to determine how many staff members were needed each day in the OPD. As appointments and surgery was planned in advance the service was able to plan patient care in advance and co-ordinate staff to patient procedures and appointments.
- All the nursing staff we spoke with told us that they thought that there was sufficient staff available to manage their workloads appropriately.

- Records submitted before the inspection did not divide the staffing levels into surgery and OPD. The service supplied information that stated the establishment (i.e. staff needed) was 6.4 whole time equivalent (WTE) nursing staff. The information further stated there were four full time nursing staff and four part time nursing staff.
- Additionally there were 12 bank staff that worked as and when they were needed. All bank staff worked regularly in the service or had previously worked there. The service had not used any agency staff in the previous 12 months. As such staff members employed were experienced in working in the service and familiar with the job role.
- We saw that the staffing structure was flexible and nursing staff in OPD could support surgery if and when required.

Medical staffing

- Information supplied by the service showed there were five optometrists undertaking pre-operative checks and referrals for surgery as needed. They all worked in the hospital under practicing privileges. Practicing privileges are a 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
- There was an optometrist employed by the service on a part time basis (0.8 WTE) who provided support and leadership to the other optometrists.
- For our detailed findings on medical staffing for this core service, please see the Safe section in the Surgery report.

Emergency awareness and training

- For our detailed findings on emergency awareness and training for this core service, please see the Safe section in the Surgery report.

Are outpatients and diagnostic imaging services effective?

We did not rate effective.

Evidence-based care and treatment

- Records reviewed and discussions with management demonstrated that the service utilised both national policies and procedures developed by Optegra as well as local policies. Clinical guidance that was incorporated in policy was reviewed at a company national level as well as at local level to maintain continuity of care and support and develop consistent implementation.
- The policies we reviewed cited and included relevant best practice guidance such as National Institute for Health and Care Excellence (NICE) guidance for the treatment of Glaucoma and Macular diseases.
- Records and staff confirmed that when patients did not attend appointments or dropped out of treatment they were reviewed and contacted to determine if they still required the appointment.
- We saw that the service had a policy that patients start their treatment by a clinical assessment which involved a review by an optometrist prior to being seen by the consultant. Where a patient was deemed unsuitable for treatment an explanation in writing was provided to them and this was undertaken in line with best practice guidelines in order to maintain patient safety.
- For our detailed findings on Evidence based care and treatment for this core service, please see the Effective section in the Surgery report.

Pain relief

- The outpatients department provided limited forms of pain management and no formal pain screening process. The only form of pain relief given at pre and post-surgery consultations was anaesthetic eye drops
- We were informed by staff that patients were advised on pain relief during discharge discussions. However these discussions were not recorded in patients' notes in order to determine and record that the best advice and support had been given.
- Records available and staff discussion showed that private patients were given a 24 hour helpline number to contact if they needed pain relief. NHS patients were told to contact their local NHS provision if needed. All patients were given discharge information that if the pain was severe they should go to their local accident and emergency department. There were no incident records available that showed any patients had experienced severe pain after discharge.
- Patients returning for after care appointments informed us that they had experienced little to no pain.

Nutrition and hydration

- Due to the nature of the service, the OPD did not provide food and drink specifically. We observed that there was a hot drink machine and biscuits available in the reception area that patients were observed to freely access. Patient's relatives were also encouraged to access this provision.

Patient outcomes

- Records we reviewed showed that patients with non-surgical conditions such as glaucoma were monitored according to the service's policy, patient's individual needs and the contract in place with the NHS. Information regarding patient monitoring and outcomes was reported directly to the NHS in order to make sure that patient's outcomes continued to be monitored.
- Optegra Manchester benchmarked itself against the other Optegra hospitals. The eye sciences department completed a report which was fed back, quarterly, to the medical advisory committee. The report covered; local bench marking, UK bench marking and International bench marking. We were provided with a Clinical outcomes report which reviewed complication rates and clinical outcomes data for laser vision correction, RLE and cataract procedures performed at that hospital. Comparative data from the previous three quarters and a summary of patient outcomes data was also provided.
- For our detailed findings on Patient outcomes for this core service, please see the Effective section in the Surgery report.

Competent staff

- Staff told us they had good access to training regarding their professional development. Training records reflected a variety of training including additional training above mandatory training such as dementia, stress awareness and equality and diversity.
- All nursing staff spoken with and records reviewed indicated that that 100% of staff had received an appraisal within the last 12 months. Staff told us that they found this of use and that there was ongoing informal supervision that assisted them in identifying areas of skill they wished to develop.
- We saw that nurses worked in both OPD and surgery when required. In general they remained within their chosen work areas. Nursing staff and consultants also worked across both the Manchester and Altrincham sites. The staff had a varied skill mix and often had extra roles in the organisation. An example of this was a member of the nursing staff had taken responsibility for leading on infection control and another trained to act as the Laser Protection Advisor who has responsibilities in making sure that local laser safety was maintained.
- Management and staff told us that they supported student nurse placements in order to assist both the development of student nurse skills and their own staff member's exposure to different practice and views. The service had supported a member of staff to develop their skills to the point of being successful in gaining a placement as a student nurse.
- We spoke with staff dispensing medicines and reviewed the policy which outlined that this was an "extended" nursing role. Staff spoken with and management confirmed that specific training and assessment of competency to undertake this specific task had not been undertaken. Management confirmed that this would be addressed as a priority.
- For our detailed findings on competent staff for this core service, please see the Effective section in the Surgery report.

Multidisciplinary working

- Records showed and staff confirmed that a team meeting was held on a six monthly basis, which included staff from across the disciplines. The purpose of the meeting was to enhance shared learning and build team collaborative working.
- All staff we spoke with told us that all the disciplines worked well together and there was a mutual respect for each other's profession. They also stated that thought they had good working relationships with other service providers such as general practitioners (GP's) and opticians. Patients' records reflected that pre and post treatment information was sent to patients relevant external medical professionals.
- Staff and management told us that the service also undertook a weekly lecture night when members of the public and other professionals were invited to attend in order to share learning, build relationships and enhance practice. This was also widely advertised on the services 'website and explained what topics were to be covered.
- For our detailed findings on Multidisciplinary working for this core service, please see the Effective section in the Surgery report.

Access to information

Good

Outpatients and diagnostic imaging

- We looked at how information needed for staff to deliver safe treatment was made available. We saw that patient files were made available for each appointment and for staff to monitor patients after their surgery.
- Records showed that information was sent to relevant external professionals as required by the patients.
- Discharge information we reviewed did not consistently include relevant information about medicines. Patients were given verbal information, on when and how to take the prescribed medicine. However this was not recorded in the patients' records in order to make sure that this information was consistent and fully understood by the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff working in the outpatient department demonstrated a clear understanding of how to gain patient consent and the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff members spoken with gave examples of when patients might lack the capacity to make their own decisions and how this would be managed.
- We observed records that demonstrated the mental capacity of a patient to consent to treatment was reviewed by consultants and staff nurses during consultation and the pre-operative assessment stage.
- For those patients who lacked capacity a decision was made whether their needs could be accommodated based on the type of treatment they sought. Where it was determined that the patient did not have capacity a best interests discussion took place and if the treatment was in the patient's best interest and could be accommodated within the service arrangements were made that maintained the patients safety and rights.
- For our detailed findings on Consent, Mental Capacity Act and DoLS please see the effective section in the Surgery report.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- We observed staff interaction with patients these were positive in nature. Some patients return frequently to the service and the familiarity of staff with individual patients was observed as warm and welcoming. Patients spoken with told us that, "Staff are very caring and welcoming", "I am listened to my view matters", and "staff are very friendly and calm".
- We saw positive interaction from staff in clinic rooms and waiting areas, consistently throughout the inspection. Staff were kind towards patients, joking and smiling with them and putting their mind at ease.
- Patients spoken with told us that that they were treated with dignity and respect by all staff members. All patients we spoke with said they found the staff polite, friendly and approachable.
- We observed that staff respected patient confidentiality and ensured discussion took place in treatment rooms. At reception patients were not asked to provide confidential information such as name and address.
- Staff told us and we observed that patients' relatives were supported to attend appointments and this occurred several times whilst we observed staff support to patients. Staff told us relatives were welcomed and supported to attend with their family member.
- We observed that there was an inconsistent approach from staff greeting patients. The majority introduced themselves to patients in order to set them at ease others did not.
- The majority of time we saw that patient's dignity was respected and maintained. We did observe on one occasion a patient could be observed lying on an examination couch from the main corridor. We brought this matter to the attention of a senior member of the management team who immediately addressed this by closing the door.
- For our detailed findings on compassionate care for this core service please see the Caring section in the Surgery report.

Understanding and involvement of patients and those close to them

- All patients and relatives we spoke with told us that care and treatments were explained to them and their relatives. Patients told us they felt involved in their care

and their appointments were not rushed. Comments included, "it was all well explained to me", and "All the staff give the impression of really wanting to help and support you".

- During our observations we saw staff reassuring patients and giving them time to understand the treatment they were due to have.

Emotional support

- We spoke with patients and their relatives who told us they felt supported and staff members were warm and welcoming. Records showed and was confirmed by patients that they were given verbal information and support regarding their treatment.
- Patients told us that the staff put them at ease on arrival.
- Records showed that many of the patients had a diagnosis of long term conditions such as Age related Macular Degeneration (AMD) where the patients' central vision deteriorates or glaucoma where the optic nerve is damaged by the pressure of the fluid inside the eye. Both these conditions can cause significant sight loss. We saw that information on support groups such as RNIB who provide advice to people with sight loss was available.
- Throughout our visit we observed staff giving reassurance to patients with additional support given when it was required, especially if patients were apprehensive.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- All patients we spoke to felt comfortable in the waiting areas at the hospital, where drinks facilities, magazines and information leaflets were close to hand. One patient said that 'after surgery they always come round with a drink and a biscuit.'
- We spoke with patients and staff who confirmed that all appointments are planned in advance. As such, the service was able plan clinic sessions and use appointment information to identify number of patients who would be attending each day. They had the ability to decrease or increase the number of clinical appointments required to meet the needs of patients and to maintain flexibility of staff.
- Records and discussion with senior management identified that the service had ongoing relationships with four Clinical Commissioning Groups (CCG's) who commissioned their services. The CCG's had active monitored contracts with the service for NHS patients to receive treatment.
- The service had opening times of; Monday to Thursday from 8am to 8pm, Friday 8am to 6pm and Saturday 8am to 4pm in order to meet patients' needs. There were two locations; one at Manchester and one at Altrincham to provide additional services for patients in the community.
- We were informed by management and staff that one of the developments for the future was to have a second operating theatre it had been anticipated that this would need additional facilities for patients both pre and post theatre and action had been taken to provide this additional support.
- For our detailed findings on Service planning and delivery to meet the needs of local people for this core service please see the Responsive section in the Surgery report

Access and flow

- Patients were able to arrange OPD appointments via a range of means. Self-paying and insured patients were able to self-refer without a GP or optician's referral.
- Management and staff spoken with confirmed that the service did not monitor waiting times, both prior to an appointment being arranged or when the patient arrived for their appointment. Patients told us that they did not wait long before they got an appointment however some patients spoken with told us that they did wait for up to an hour before they were seen.
- We observed staff try to make sure that patients got an appointment of their choice, sometimes on the day of referral. We saw one patient call the hospital and was offered several different appointments. Another patient spoken with said they were pleased as to how fast they got an appointment.

Good

Outpatients and diagnostic imaging

- We were informed by staff and saw records that confirmed that patients living with Age related Macular Degeneration (AMD) were a priority for treatment. This was because that once diagnosed delays in treatment could be detrimental to patients' sight.
- Staff and patients confirmed that where patients did not attend any appointments the service contacted them within 48 hours to follow up and rearrange an appointment as needed.
- We spoke to a number of patients on inspection and found that they had waited between ten and 14 days.
- One patient told us that after their first surgery they requested an extra appointment with the ophthalmologist regarding the best treatment options and this was arranged quickly.
- We observed patients in the waiting room and those spoken with told us they had not had to wait long before being called for their appointment.
- For our detailed findings on Access and flow please see the Responsive section in the Surgery report

Meeting people's individual needs

- We observed that information was available to patients about who to contact if they had any concerns about their care. Additionally there was a wide variety of information leaflets available in both waiting areas. We asked staff and patients if information was available in different formats such as braille, large print or other languages. Staff and management confirmed that different formats were available if requested but were not readily available on site. The availability of information in formats to meet the needs of people with impaired sight would benefit patients in their understanding and involvement of the treatment they are to receive.
- The waiting area was spacious with separate offices that supported staff and administrators and staff to have private discussion if need be. The services also had confidential interview and clinic rooms, which enabled staff and patients to have private discussions.
- The environment was observed to be pleasant but we saw that there were limited adaptations to people living with dementia or a learning disability, such as appropriate signage. Staff spoken with and management were not aware of a specific dementia or learning disability strategy. However, training for staff was available in dementia awareness, staff stated that they had enjoyed this training and found it of benefit.
- We observed staff worked closely with patients and saw the same staff supported patients on their return to the hospital. Information was not easily available in different formats or languages but could be ordered in advance if required. Staff we spoke with could not recall an occasion when information had been made available in different formats or languages.
- Car parking was observed to be available at the Manchester site but was limited at the Altrincham site. The lack of car parking spaces meant that patients and carers sometimes needed to park on local roads or pay for car parking. There was a large car park within walking distance of the Altrincham site.
- For our detailed findings on Meeting people's individual needs please see the Responsive section in the Surgery report.
- We spoke with staff and patients who informed us that there was assistance for people who required additional support to communicate such as a loop system to assist in hearing and translation service for patients who would benefit from these services. We saw that loop system equipment was available in the majority of areas at both sites of Manchester and Altrincham.

Learning from complaints and concerns

- The hospital had a complaints policy in place, this was in date, reviewed and updated regularly and was accessible to staff.
- The outpatient department displayed their complaints leaflet that informed patients of how to complain.
- For our detailed findings on Learning from complaints and concerns for this core service please see the Responsive section in the Surgery report.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as required improvement.

Leadership and culture of service

- There was no separate manager for the outpatients department. The Hospital manager also oversaw the management of this department.

Good

Outpatients and diagnostic imaging

- Staff we spoke with who worked in Outpatients Department (OPD) told us that they were aware that providing quality care and being a national leader was important to the service. They spoke about their ability to recruit the best staff including surgeons.
- Senior management told us that they invested in staff through training and awards for staff when they delivered outstanding practice.
- All staff spoken with in OPD told us that they felt very well supported and enjoyed working in the service. They told us that there had been recent changes in the leadership but they were confident that the new management team understood the service and the staff.
- For our detailed findings on Leadership and culture of service please see the Well led section in the Surgery report

Vision and strategy for this core service

- The provider's vision was 'To ensure Optegra UK is a market leading profitable provider of first choice, famous for Patient service and eye care excellence because we look after our colleagues, who look after our Patients'. The values were found on the website, but not displayed around the hospital
- All staff members we spoke with in OPD were aware of the vision and strategy of the service.
- For our detailed findings on Vision and strategy for this core service please see the Well led section in the Surgery report.

Governance, risk management and quality measurement

- The risk register for the whole service covered risks from both surgery and OPD.
- All staff members we spoke with in OPD were aware of the governance arrangements. They described how management checked the quality of the service and informed them of where improvements needed to be made.
- There was evidence of governance meetings, both corporately and locally, where managers discussed and reviewed risks and incidents. Staff we spoke and copies of the minutes reflected that OPD staff attended the service-wide meeting
- For our detailed findings on Governance, risk management and quality measurement for this core service please see the Well led section in the Surgery report.

Public and staff engagement

- For our detailed findings on Public and staff engagement for this core service please see the Well led section in the Surgery report

Innovation, improvement and sustainability

- For our detailed findings on Innovation, improvement and sustainability for this core service please see the Well led section in the Surgery report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must finalise, embed and adhere to a Standard operating procedure as referred to in the medicines management policy with regards to staff dispensing medicines**.**
- The provider must follow its own policies.
- The provider must follow action plans and pass learning onto staff when an investigation has been completed as a result of an incident.
- The provider must carry out audits in order to monitor the effectiveness of the care and treatment delivered to patients.
- The provider must ensure that all staff are competent to undertake the activities required to carry out their role.
- The provider must audit staff compliance with their policies, including observational checks, to ensure the safety of patients.
- The provider must implement the surgery check list they have in place, in a manner that mitigates risks to patients.
- The hospital must ensure it identifies, grades and reports serious incidents and never events in line with its own policy and external reporting obligations.
- The hospital must ensure an effective process for managing risks to the service which follows up and reviews actions in a timely way.

Action the provider SHOULD take to improve

- The provider should consider taking actions so that all patients are given enough support and opportunity to be fully involved in the planning of their own care.
- The provider should consider conducting further analysis to understand the reasons for high staff turnover.
- The hospital should ensure they have in place a transparent patient admission and exclusion criteria policy which clearly describes who is they are or are not able to treat at this facility.
- The hospital should ensure staff and managers are fully aware of the duty of candour processes, which incidents these apply to and how these should be implemented in practice.
- The hospital should ensure that any audits, identification of risks and the monitoring of quality are robustly managed and actioned.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe care and treatment 12.-(1) Care and treatment must be provided in a safe way for service users. (b) doing all that is reasonably practicable to mitigate any such risks (c) Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. (g) the proper and safe management of medicines The provider did not ensure the persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely; There was no Standard operating procedure as referred to in the medicines management policy with regards to staff dispensing medicines. Staff did not fully adhere with your own 'World Health Organization (WHO) Surgical Safety Checklist' policy. Individual competencies were not in place for tasks such as the dispensing of medicines to take home, nurse led discharging and pre-operative assessments.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good governance

17 17(2)(a)

Systems and process were not operated effectively to enable the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk;

Actions recommended as a result of an investigation identified failings within surgical safety processes, some of the recommendations had still not been implemented in full.

This is because:

The provider did not have effective systems in place to assess, monitor and improve the quality of the service.

There was no evidence of staff members monitoring the compliance of the WHO Safety check list, or making observational checks to ensure the safety of patients.