

Wrightington, Wigan and Leigh NHS Foundation  
Trust

# Wigan Health Centre

## Quality Report

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

### Ratings

Overall rating for this hospital

Good



Outpatients and diagnostic imaging

Good



# Summary of findings

## Letter from the Chief Inspector of Hospitals

We inspected Boston House as part of the comprehensive inspection of Wrightington Wigan and Leigh NHS Foundation Trust

Our key findings were as follows:

- Staff were experienced and had good levels of training and competency to carry out their role. The unit was effective at identifying and reporting incidents and safety concerns. Lessons were learnt when things went wrong and action was taken by staff when improvements needed to be made. The outpatients and diagnostic imaging service developed the service they provided by improving quality and safety by actively looking for ways to improve.
- Staff compliance with mandatory training was satisfactory and staffing levels were sufficient to safely meet the needs of patients. The environment was visibly clean and hygienic and equipment was clean and maintained correctly.
- Care was planned and delivered in line with evidence based guidance and practice. Staff followed National Institute of Clinical Excellence (NICE) guidelines and adopted best practice for eye care treatment and diagnosis. There was a good multidisciplinary team with good access to a range of specialties. We found that teams worked well together and worked flexibly to support each other and the needs of the patients. This led to a holistic service for patients who reported good outcomes following their treatment.
- Patients told us they felt they received an excellent service. They reported that the staff were kind and considerate and that they were treated with respect and dignity, they said they were listened to, kept informed and were involved in the treatment they received.
- The outpatient and diagnostic imaging service met the national target time of 18 weeks between referral and treatment known as referral to treatment times (RTT). They responded to individual patients' needs and tailored services to meet the individual patient requirements. They listened to patient feedback and complaints and responded by modifying revising processes to improve the patient experience.
- The unit was well led on a local level, staff felt valued, supported and listened to and there was a positive culture within the unit. However, local management sometimes failed to adhere to quality assurance reporting practice to document the work they had done. Though action was taken managers could not always offer written evidence of this.

However, there were areas of practice where the trust could make improvements.

The unit should:

- The unit should ensure improvements to quality assurance documentation to record the actions taken to address issues following audits, investigations and action plans.
- The unit should comply with Trust resuscitation policy and use standardised equipment. They should obtain a further defibrillator, an arrest trolley and emergency medicines and provide access to such equipment on both floors of the unit.

The unit should establish and use a formal process for assessment of mental capacity; this should be documented in patient's notes. They should document their determination of best interests when they undertake this process and record the options and final decision in the patient's records.

Professor Sir Mike Richards

# Summary of findings

**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Outpatients and diagnostic imaging

### Rating

Good



### Why have we given this rating?

We found the outpatient and diagnostic imaging service at Boston House Eye Unit to be good overall.

Staff were experienced and had good levels of training and competency to carry out their role. The unit was effective at identifying and reporting incidents and safety concerns. Lessons were learnt when things went wrong and action was taken by staff when improvements needed to be made. The outpatients and diagnostic imaging service developed the service they provided by improving quality and safety by actively looking for ways to improve.

Staff compliance with mandatory training was satisfactory and staffing levels were sufficient to safely meet the needs of patients. The environment was visibly clean and hygienic and equipment was clean and maintained correctly.

Care was planned and delivered in line with evidence based guidance and practice. Staff followed National Institute of Clinical Excellence (NICE) guidelines and adopted best practice for eye care treatment and diagnosis. There was a good multidisciplinary team with good access to a range of specialties. We found that teams worked well together and worked flexibly to support each other and the needs of the patients. This led to a holistic service for patients who reported good outcomes following their treatment.

Patients told us they felt they received an excellent service. They reported that the staff were kind and considerate and that they were treated with respect and dignity, they said they were listened to, kept informed and were involved in the treatment they received.

The outpatient and diagnostic imaging service met the national target time of 18 weeks between referral and treatment known as referral to treatment times (RTT).

They responded to individual patients' needs and tailored services to meet the individual patient requirements. They listened to patient feedback and complaints and responded by modifying revising processes to improve the patient experience.

The unit was well led on a local level, staff felt valued, supported and listened to and there was a positive culture within the unit. However, local management

# Summary of findings

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# Wigan Health Centre

## Detailed findings

### Services we looked at

Outpatients and diagnostic imaging

# Detailed findings

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## Background to Wigan Health Centre

Boston House Eye Unit is a service provided by Wrightington Wigan and Leigh NHS Foundation Trust. The

unit provides outpatient treatment, screening and diagnostic eye services. It is a stand-alone outpatient's clinic occupying two floors within a healthcare resource centre on the outskirts of Wigan Town Centre.

## Our inspection team

Our inspection team was led by:

**Chair:** Bill Cunliffe, Consultant colorectal surgeon with 6 years' experience as a medical director

**Acting Head of Hospital Inspections:** Lorraine Bolam, Care Quality Commission

The team included a CQC Inspection Manager, two CQC inspectors and a variety of specialists including a consultant haematologist and a nurse.

We did not have any Experts by Experience on the team but held a listening event on 2 December 2015 which was attended by a number of local people who had experienced the services at Wrightington, Wigan and Leigh. It was also attended by the local Healthwatch team who shared information they had received about services.

## How we carried out this inspection

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

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

The inspection team inspected the following core service at Boston House;

- Outpatients.

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

# Detailed findings

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Wrightington, Wigan and Leigh hospitals.

## Facts and data about Wigan Health Centre

The unit recorded 18,846 outpatient attendances in the six months from June 2015 to November 2015, including

8,500 diabetic retinopathy screenings and 1,800 Anti-VEGF (vascular endothelial growth factor) medication injections for the treatment of age related macular degeneration.

## Our ratings for this hospital

Our ratings for this hospital are:

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

### Notes

# Outpatients and diagnostic imaging

Safe	Good	
Effective		
Caring	Good	
Responsive	Good	
Well-led	Good	
<b>Overall</b>	<b>Good</b>	

## Information about the service

Boston House Eye Unit is a service provided by Wrightington Wigan and Leigh NHS Trust. The unit provides outpatient treatment, screening and diagnostic eye services. It is a stand-alone outpatient's clinic occupying two floors within a healthcare resource centre on the outskirts of Wigan Town Centre.

The unit recorded 18,846 outpatient attendances in the six months from June 2015 to November 2015, including 8,500 diabetic retinopathy screenings and 1,800 Anti-VEGF (vascular endothelial growth factor) medication injections for the treatment of age related macular degeneration.

We visited all outpatient and clinic areas including examination and treatment rooms, diagnostic facilities and waiting areas. We spoke to five patients, two relatives and reviewed four care records. We spoke to six members of staff, observed care and treatment, reviewed performance and assessed information about the clinic. We inspected the environment to determine if it was an appropriate setting for delivering care and treatment and for use by patients and staff.

## Summary of findings

We found the outpatient and diagnostic imaging service at Boston House Eye Unit to be good overall.

Staff were experienced and had good levels of training and competency to carry out their role. The unit was effective at identifying and reporting incidents and safety concerns. Lessons were learnt when things went wrong and action was taken by staff when improvements needed to be made. The outpatients and diagnostic imaging service developed the service they provided by improving quality and safety by actively looking for ways to improve.

Staff compliance with mandatory training was satisfactory and staffing levels were sufficient to safely meet the needs of patients. The environment was visibly clean and hygienic and equipment was clean and maintained correctly.

Care was planned and delivered in line with evidence based guidance and practice. Staff followed National Institute of Clinical Excellence (NICE) guidelines and adopted best practice for eye care treatment and diagnosis. There was a good multidisciplinary team with good access to a range of specialties. We found that teams worked well together and worked flexibly to support each other and the needs of the patients. This led to a holistic service for patients who reported good outcomes following their treatment.

# Outpatients and diagnostic imaging

Patients told us they felt they received an excellent service. They reported that the staff were kind and considerate and that they were treated with respect and dignity, they said they were listened to, kept informed and were involved in the treatment they received.

The outpatient and diagnostic imaging service met the national target time of 18 weeks between referral and treatment known as referral to treatment times (RTT). They responded to individual patients' needs and tailored services to meet the individual patient requirements. They listened to patient feedback and complaints and responded by modifying revising processes to improve the patient experience.

The unit was well led on a local level, staff felt valued, supported and listened to and there was a positive culture within the unit. However, local management sometimes failed to adhere to quality assurance reporting practice to document the work they had done. Generally, it was accepted that actions had been taken, but managers could not offer evidence of this when requested.

## Are outpatient and diagnostic imaging services safe?

Good



We found the outpatient and diagnostic imaging service at Boston House Eye Unit to be good for providing safe care

The eye unit had a good record on safety and showed evidence of reporting incidents. Staff were encouraged and supported by managers. Staff demonstrated that when incidents did occur, incidents were reviewed and where applicable lessons were learned from them. Information was used to make changes to processes, which led to improvements in service and safety.

All areas including clinics, examination and treatment rooms, waiting areas, toilets and communal areas that we inspected were visibly clean and hygienic. There were effective cleaning programmes; however, managers did not provide evidence that audits of cleaning regimes were completed.

Staff were trained in emergency life support, and there was equipment available that was shared by two departments. Staff said this had been risk assessed by the resuscitation team, who determined that there was sufficient resuscitation equipment, and that emergency drugs were not required; however, they were unable to supply a copy of this risk assessment when requested.

Medical and nursing staffing levels were sufficient to keep people safe. Staff received training in safeguarding and other mandatory training and were competent in delivering this in practice. The service had good systems for identifying, recording and responding to risks and had put in place procedures for analysing and learning from incidents.

### Incidents

- There were no 'never events' for the period June 2015 to November 2015. 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There was one 'serious incident requiring investigation' reported for the period June 2015 and November 2015. This incident was still under investigation at the time of

# Outpatients and diagnostic imaging

the inspection. The patient had been involved in the investigation process and we were informed that Duty of Candour had been used. Duty of Candour is a regulation introduced for all NHS bodies in November 2014; it encourages hospitals to act in an open and transparent way when things go wrong and sets out what a hospital must do if harm has been caused to a patient. The team understood the Duty of Candour processes and were aware of the procedures and their obligations. We reviewed the initial investigation and were satisfied with the actions taken.

- The service showed evidence of reporting incidents and staff were encouraged and supported by managers. Staff demonstrated that when incidents did occur, they were reviewed, analysed and lessons were learned from them. The information was then used to make changes to processes, which led to improvements in the quality and safety of care that patients received. We saw evidence that this process was effective and saw examples of changes made as a result of lessons learnt.
- Ten incidents were reported between May and August 2015, eight resulted in no harm and two resulted in low harm to a patient.

## Cleanliness, infection control and hygiene

- All areas were visibly clean and tidy. Cleaning audits were requested, but managers were unable to show that these had been completed.
- Staff followed trust policies and procedures in relation to the control and prevention of infection.
- There were sufficient supplies of hand washing facilities and personal protective equipment such as aprons and gloves.
- The latest trust hand hygiene audit in August 2015 showed Boston House Eye Hospital achieved 100% compliance.
- The unit did not routinely screen for healthcare related infections such as Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (CDiff). However, the unit reduced the risk of cross infection where staff were aware of risks. Staff complied with infection control procedures and if required could arrange a 'deep clean' of facilities.

- Toilet facilities were provided on both floors of the unit. During our visit, we saw that they were clearly signposted, well equipped and maintained and records were kept of when they were cleaned.
- Staff monitored the cleanliness of the environment and housekeeping. Staff were available to carry out additional cleaning when necessary.

## Environment and equipment

- The design and layout of facilities were organised and logical. The unit had changed the layout of clinical areas over two years since opening to improve the patient journey.
- Laser equipment was available in two rooms and room facilities had been approved for use as per Medicines and Healthcare products Regulatory Agency (MHRA) 'Laser Guidance' 2015. Signage was appropriate to warn of radiation risk and equipment was serviced every 6 months as per Medicines and MHRA guidance.
- The unit had completed risk assessments on the use of the laser equipment and staff members were trained on the use and risks of radiation. Staff used appropriate personal protective equipment (PPE) whilst delivering radiation treatment.
- Laser machines were serviced and maintained, including tests for legionella and records were kept appropriately as per MHRA guidance. Four members of staff were trained laser protection supervisors as per the requirements of the MHRA guidance and we saw their certifications during the visit.
- Staff attended regional meetings relating to radiation and laser safety as part of their responsibilities as radiation protection supervisors. Minutes of meetings were recorded and kept in a file for staff to refer to. This supported the safe use of equipment for staff and patients in the unit.
- Waste and clinical specimens were managed and disposed of safely and in line with trust policy. The unit had an effective and safe system of sorting, storage, labelling and handling of waste and we observed that they adhered to this. A recent audit was completed and the unit acted upon advice to improve safety.
- Equipment was clean and well maintained. Once used equipment was cleaned and labelled as clean.

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- The unit used single-use, sterile instruments where possible. Single use instruments were within their expiry dates and were disposed of appropriately in line with trust policy.
- The unit had arrangements for the sterilisation of reusable instruments. There was sufficient storage space in the unit and items were appropriately stored in a tidy and well-organised way.
- All equipment was serviced and checked regularly and was labelled accordingly. This process was handled by an external contractor and the unit kept a computer log of when items needed servicing or portable appliance testing. All the equipment we saw was in date and serviced appropriately.
- There was no bariatric chair or equipment in the unit. If this was required, it could be arranged in advance.

## Medicines

- Medicines were stored safely and in line with agreed protocols.
- Medicines requiring cool storage were stored appropriately and records showed that refrigerators were kept at the correct temperature. These were checked daily and audited appropriately.
- Systems were in place for prescribing medicines safely.

## Records

- The service used both paper and electronic patient records.
- We reviewed three paper patient records and found these to be accurate, complete, legible and up to date.
- We reviewed three electronic patient records and found this to be an effective tool for recording and reporting. It was particularly useful for giving patients visual feedback to explain their eye condition and show any deterioration.

## Safeguarding

- Staff were aware of their responsibilities around safeguarding and knew the correct procedures to follow. Staff were trained and received annual updates in safeguarding but had not had cause to use the process.

- The hospital had two dedicated safeguarding nurses, one for adults and one for children. Staff were able to contact this team for advice and information.

## Mandatory training

- The trust completed a training needs analysis, which identified mandatory training requirements for individual roles and responsibilities.
- Staff received mandatory training in areas such as safeguarding, infection prevention and moving and handling. This was delivered either face to face or via online learning. Line managers monitored compliance levels to ensure training was up to date.
- Compliance with mandatory training was 98.6% for the optical services unit.

## Assessing and responding to patient risk

- The unit was a stand-alone site in the community, and did not have an emergency response team or bleep holder. This was similar to other centres of similar nature. There were policies in place for dealing with emergencies and the process was to dial 999 and wait for ambulance and paramedic assistance.
- Staff were trained in basic life support (BLS) and this was updated annually. The unit were compliant with mandatory updates. Trust policy stated that the use of an automated External Defibrillator (AED) was “an integral component of BLS”.
- There was not a resuscitation trolley within the unit. There was one ‘shock box’ AED and some anaphylaxis medications available for staff to use in an emergency. This was not in keeping with the trust’s resuscitation policy. The policy stated that equipment and drugs should be standardised across the trust. The unit advised us this had been risk assessed by the resuscitation team at the trust, who determined that resuscitation equipment and emergency drugs were not required. However, they were unable to supply a copy of this risk assessment when requested.
- The shock box (AED) was shared between two floors on the unit. In the event of a cardiac arrest, Resuscitation UK guidelines and the trust’s own resuscitation policy

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stated that a shock should be administered within three minutes of a collapse. However, if a collapse occurred on another floor of the unit, it may be difficult to deliver treatment within three minutes.

## Nursing staffing

- At the time of our visit, the unit was experiencing some long-term sickness amongst nursing staff, which led to gaps on the rota. This was being managed by staff undertaking extra shifts and the manager and ward sisters (who were advanced nurse practitioners) undertaking clinical work.
- Staffing was planned to ensure there was enough nursing staff with the appropriate skills and abilities to deliver safe care. Registered nurses and health care assistants received training to undertake extended roles to operate equipment and undertake some diagnostic procedures.
- The ward manager had the ability to amend clinics and reallocate staff up to the day of the clinic. This worked well and was supported by a flexible team and meant it had not been necessary to cancel clinics or appointments due to staffing issues.
- The unit used their own staff on bank shifts, but did not use external agency nurses because of the specialist nature of their work.

## Medical staffing

- The unit was supported by 10 medical staff and ophthalmologists who undertook consultations, diagnostic and treatment procedures. At the time of inspection, the unit employed one long-term locum medic, but the trust had successfully recruited to this vacancy.
- The unit used eight non-medical practitioners who undertook some diagnostic and clinical procedures, which supported
- Staffing was organised to support safe and effective patient care, and there was an effective mix of skills and abilities at all times.

## Major incident awareness and training

- The unit had contingency plans in place for major incidents, for example, fire and bomb threats. Staff undertook procedure drills every six months.

## Are outpatient and diagnostic imaging services effective?

The unit followed available evidence based practice and National Institute for Clinical Excellence (NICE) guidelines in the provision of care and treatment. Staff adopted best practice and efficient care pathways to deliver effective care and treatment. Patients felt positive about their treatment and pleased with their outcomes following treatment.

Care was delivered by a specialist and skilled multidisciplinary team, which provided some one-stop facilities and clinics. Staff had access to effective electronic and manual patient records, which were comprehensive and easily accessible. Patients' autonomy was protected by satisfactory systems for consent, but there was some uncertainty over the application of mental capacity assessments and documentation of decision-making.

## Evidence-based care and treatment

- The latest evidence based guidance and best practice was followed on the unit, for example diabetic retinopathy screening, age related macular degeneration and macular oedema protocols.
- The unit participated in NHS England key performance indicators (KPIs) and submitted three monthly information regarding services that were provided. We reviewed the latest report, which showed they were meeting targets.
- The unit had established care pathways and used proformas for patients having cataract treatment, minor eyelid procedures and fundus fluorescein angiography. We reviewed care pathways and proformas and found them to be complete, comprehensive and clear.
- NICE guidelines and best practice guidance was available to staff via the trust's intranet. We found that staff followed local policies and procedures. Hard copies of policies and protocols were kept in the managers' office for staff to refer to if needed.
- Staff were provided with regular updates during staff meetings and via email when guidance or practice was changed.

## Pain relief

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- The unit used local anaesthetic for procedures and occasionally administered paracetamol, however they did not provide nor require any other analgesia as this was not called for given the type of treatment provided.
- Patient feedback suggested that some patients who had ophthalmic procedures following tests and pre-operative assessments were not prepared for the level of pain they experienced following surgery. To reduce this, pain prevention and control was explained fully at the pre-operative assessments so that patients were fully informed and aware of what to expect of their procedure.

## Patient outcomes

- The unit participated in the NHS England key performance indicators related to outcomes in diabetic retinopathy screening and they met the required standard.
- The ratio for follow-up to new appointment rate at trust level between January 2014 and December 2014 was higher than the England average.
- Patients reported favourable outcomes after treatment and were pleased with the improvements in their vision. Outcome feedback was collected from a listening event with 50 former patients. This was arranged through the trust public engagement team. The feedback was positive and they were told that former patients were very happy with the outcomes of their treatment.

## Competent staff

- Staff were competent and experienced in the specialist area they worked.
- Staff had additional qualifications in ophthalmology and optometry.
- Staff were certified in the safe use of laser equipment as per MHRA guidance.
- Staff were encouraged to develop and extend their roles to take on extra responsibilities. For example, some health care assistants had received training and were competent to operate the vision boxes and perform tests.

- Staff were encouraged to undertake clinical skills competencies and become practitioners. This benefitted their career progression, job satisfaction and assisted with the efficient running of the unit.
- Appraisal rates for staff were 87.1%. Staff stated they had face-to-face annual appraisals. Appraisal figures showed the unit were compliant with this process.

## Multidisciplinary working

- Optometrists, ophthalmologists, nurses, support workers, non-medical practitioners, doctors, technicians, managers and administrative staff worked together as a multidisciplinary team.
- Team members expressed that they felt part of a team, that they worked well collectively and that the team was inclusive and supportive.
- Members of the multidisciplinary team all had roles in the assessment, planning and delivering of patients' care and treatment. At the beginning of each session, the team had a briefing to discuss any issues regarding cases for that day. They operated a 'one-stop' clinic where different types of tests could be done on the same visit.
- Staff worked together to progress the patient's journey through clinics. Patients we spoke with believed their treatment was organised and well planned.
- The unit operated a good direct referral scheme with local GPs and opticians. If there was concern, the unit would arrange to see patients through the urgent care clinics at short notice.
- Multidisciplinary team meetings were held every two months. The team felt these were beneficial for effective team working and for team building.

## Seven-day Services

- The unit operated Monday to Friday from 8.30am until 5.00pm; they occasionally ran clinics on a Saturday to reduce waiting times on an ad hoc basis.

## Access to information

- Electronic patient records stored comprehensive information and images. Staff were able to review

# Outpatients and diagnostic imaging

historical images. This enabled practitioners to clearly determine any deterioration in the patient's condition, and was a very effective tool to show patients a visual description of their condition.

- The unit had good access to patients' paper health records from the trust storage facility. It was only on rare occasions that staff did not have to hand paper records, in which case a temporary file was established and used in conjunction with electronic records.
- Communication with GPs was good. GP's and opticians could refer a patient to the unit directly. This reduced the time it took for patients to get an appointment.
- Following treatment, GP's were sent a letter detailing the outcome of the clinic attendance and what the plans were for the patient. These were either automated computer issued letters or were typed by medical administrators following dictation by the practitioner.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received training on the Mental Capacity Act 2005 as part of mandatory training packages and were compliant with training updates. However, we found that not all staff were fully aware of the requirements of the Mental Capacity Act or how to ensure that people's capacity to consent was assessed and recorded appropriately.
- There was not a formal procedure in place when they suspected a patient lacked capacity. Staff described a process where they would continue treatment as this was in the patient's best interest, but this did not involve a formal process or recording the assessment of capacity and the determined best interest's decisions.

## Are outpatient and diagnostic imaging services caring?

Good



We rated services as good in the caring domain.

Patients reported that staff were kind and considerate and that they were treated with respect and dignity. Patients

said they were listened to, kept informed and were involved in the treatment they received. They said they were afforded sufficient time with the practitioners and were given chance to ask and have their questions answered.

We witnessed positive and friendly interactions between staff and patients and saw that staff were respectful and courteous to relatives and carers.

## Compassionate care

- During our inspection, we saw staff introducing themselves and interacting with patients and relatives in a positive and supportive manner.
- We saw that staff appeared kind and courteous and showed compassion to their patients.
- We observed staff helping people around the different areas of the unit. Staff approached people rather than waiting for them to ask, they checked on people and showed them where to go.
- The feedback cards that patients completed were overwhelmingly positive and complimentary about the staff and their attitudes.
- The patients we spoke with during our visit described staff as very kind and caring. A patient told us a doctor had arranged to see him during the doctor's lunch break as there were no appointment slots.

## Understanding and involvement of patients and those close to them

- Patients and relatives told us they felt members of staff were respectful and listened to their point of view. Patients said they were given sufficient time to ask questions and that all their questions were answered.
- Patients said they received clear information about their care in a way they understood which enabled them to make informed choices about treatment options. This was supported by what we saw during our visit.
- Patients and relatives told us they felt involved in the decision making about their care and treatment and were able to contribute to decision making.

## Emotional support

- Staff at the unit provided emotional support to patients during their clinic appointments.

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- The unit provided patients with condition advice booklets and leaflets, which gave additional information and support.
- The unit provided a telephone number, which patients could call for assistance or advice following their treatment. If necessary the patient could be seen before their next appointment.
- The unit used several clinical nurse specialists, who gave advice and support to patients regarding their eye conditions and associated emotional support as required.

## Are outpatient and diagnostic imaging services responsive?

Good



We rated services as good in the responsive domain.

The unit delivered services which met the needs of local people and provided a good range of treatments and diagnostic procedures. The unit provided a good service within appropriate facilities, which included some one stop clinics where a patient could undergo all their tests and be given a diagnosis on the same visit.

Patients could see practitioners within a few days via the urgent referral clinic if this was deemed necessary by their GP or optician. Patient referral to treatment times were within national targets.

The unit was responsive to the feedback from patients and staff. Changes were made in response to areas of concern or where improvements could be made.

### Service planning and delivery to meet the needs of local people

- A range of specialist eye investigations, treatment and follow up clinics were provided at Boston House Eye Unit. Services were planned and designed with the surgical unit at Leigh Infirmary, to meet the needs of the local population.
- The unit operated 'one-stop' clinics for various eye conditions including Glaucoma diagnosis. This meant

patients could have their treatment and diagnosis in one go without having to return back to clinic on multiple occasions and subsequently they received their treatment sooner.

- The unit provided good facilities and an appropriate environment for the delivery of care and treatment. There were well-equipped waiting areas with suitable seating areas, reading materials, drinks machines and television where patients and relatives could wait comfortably.
- There was a well-equipped clean and safe children's waiting and play area with a range of play activities.
- The unit had a free easily accessible car park outside with lift or stair access up to the unit. The unit was clearly signposted and easy to locate upon entering the centre. There was a front desk operated by volunteers who directed patients to the correct unit.
- Patients told us that the centre was in a convenient location, which was accessible using public transport.

### Access and Flow

- Boston House Eye Unit had a did not attend (DNA) rate of 6.7% for patient appointments. This was higher than the national average, which was below 4.6%. The unit, operated a text service providing reminders regarding appointments but had not adopted any other measures to improve this rate.
- The 18 week referral-to-treatment (RTT) performance between January 2015 and October 2015 showed the trust had exceeded the 95% target and were better than the England average with an overall average of 98%.
- The unit had the capacity to put on extra clinics on a Saturday morning. Saturday clinics were held in order to reduce waiting times for appointments.
- The unit operated an urgent referral clinic when time critical assessments were undertaken. Clinics sometimes provided same or next day appointments where capacity existed, but always had availability within 72 hours for urgent cases.
- The unit did not record waiting times for patients once they had arrived in the unit. However, the unit received some feedback from patients that they spent more time in the clinic than they had expected for procedures such as those requiring the injection of dye. This was because

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of the time the patient needed to wait until the dye took effect and for the examination to be undertaken effectively. As a result the appointment letters were changed to advise patients of the length of time they should expect to remain in the unit.

- If there was a delay in clinic, the waiting times were recorded on notice boards to keep patients informed. We saw evidence of this in use, which patients said they found helpful.
- Diagnosis and test results were available immediately and there was no delay in waiting for analysis of results and tests.

## Meeting people's individual needs

- An interpreter service was available to the unit via the trust's central services, but this was required to be booked in advance. Staff also had access to 'Language Line' (a telephone interpretation service) if patients had not advised the unit of their requirements in advance.
- British sign language interpreters were available upon request.
- Patient leaflets in languages other than English could be requested if required.
- Patients with learning disabilities or dementia were prioritised if they expressed distress or if it was not appropriate to wait in shared facilities with other patients. A member of staff was trained and experienced in treating patients with learning disabilities and autism. The unit had a designated dementia champion who attended regional training and forums for dementia care.
- Staff explained that the unit often cared for patients who were very anxious and nervous. In such cases, the team offered reassurance and support. Any needs or requests expressed to the service were accommodated where possible.
- Whilst there were no bariatric chairs or equipment at the unit, if bariatric equipment was required this could be requested in advance from trust stores. The unit had not had cause to use such equipment since it had opened.
- Patients we spoke with stated they had sufficient time to discuss their personal circumstances and needs with staff and were given enough time to have their questions answered.

- Following patient feedback, staff identified that patients who had problems in both eyes, (for example cataracts and required surgery on one eye followed by surgery on the other) experienced some debilitating problems. This was a particular concern for patients who were left with a big difference in vision between both eyes. Patients stated they felt vulnerable and lacked co-ordination between treatments. As a result, the unit prioritised those people with large deviations between eyes to reduce the time between procedures, and, where possible, ensured that not all patients waited more than 3-6 months between procedures. This initiative was still under review and had not been evaluated at the time of this inspection.

## Learning from complaints and concerns

- Complaints were handled in line with trust policy and complaints handling was monitored centrally by the trust. Patients and families were contacted by the unit manager who discussed issues and addressed them where possible. Many were diffused at this stage and were subsequently recorded as concerns rather than complaints.
- When a complaint was not resolved, patients were directed to the Patient Advice and Liaison service (PALS). If they then still had concerns, they would be advised to make a formal complaint.
- Trust data showed nine complaints had been recorded for ophthalmology services; however, it was not clear if these related to Boston House Eye Unit or their partner location at Leigh Infirmary.
- The unit had received some complaints about the services, one was of serious concern and was subsequently recorded as an incident. This was acted upon and processes were immediately changed to prevent reoccurrence.
- Staff described how they responded positively when patients did raise concerns and they saw this as an opportunity to learn and make improvements. We observed several examples of changes made on this basis.

**Are outpatient and diagnostic imaging services well-led?**

# Outpatients and diagnostic imaging

Good



We rated services as good in providing well led services for patients and those close to them.

The unit was well led on a local level. Staff felt valued, supported and listened to. We observed a positive culture and a happy working environment. There was a good team spirit and staff demonstrated flexibility and commitment to each other and to patient care.

However, local management sometimes failed to record their actions relating to quality assurance and did not document the work they had done. Whilst it was accepted that appropriate actions had been taken, management could not offer evidence of this when requested.

## Vision and strategy for this service

- The trust vision and values were displayed throughout the unit. Staff knew about the trust values and could speak about what these meant. The trust 'wheel' symbol was well recognised and understood.
- Local managers had implemented an effective strategy since the opening of the unit two years ago. They were continuing to implement changes to assist with the smooth running of the service and this was an ongoing strategy.
- The future strategy for the unit involved the expansion of services to a wider population and bidding to provide services for other trusts.

## Governance, risk management and quality measurement

- Unit managers attended regular governance meetings with senior managers. Delegates recorded minutes of these meetings which were shared with other staff to help them keep up to date with governance issues.
- Whilst we saw some evidence of quality assurance, documentation in some key areas did not support a thorough system of audit and quality assurance. For example, the unit had a regular cleaning regime and appeared visibly clean during our inspection. However,

when we asked about their cleaning audits, managers stated there were no formal processes in place, so were unable to provide assurance that the process was effective.

- During our visit we saw evidence of some robust risk mitigation, in relation to laser protection safety. We saw that the unit had followed advice from MHRA, and had reviewed the risk assessments regularly.

## Leadership of services

- The leadership of the unit on a local level was good; the managers were well respected and were perceived to be doing a good job by the majority of staff.
- During our visit we saw that the managers worked very hard to provide a good service to the public and supported staff. In return we noted that the staff were flexible and accommodating, working extra shifts and adapting their roles to accommodate the needs of the service.

## Culture within the service

- Staff stated they felt part of the Boston House Eye Unit team, but they also felt part of the larger trust and felt proud to work for the trust. They said they were aware of the wider strategy, and the improvements and innovations that the trust had made. Staff said they were supported by the trust's senior managers.
- Staff were encouraged and supported to be open and honest if things went wrong or if they had suggestions for improvements. Staff said they felt listened to and that it was worth speaking up, as they were confident their views would be valued and acted upon.
- Teams in the unit worked collaboratively and shared the responsibility for patient care. They demonstrated flexibility and accommodated changes to meet the demands placed on them, particularly during the recent difficulties with staff sickness.

## Public engagement

- Staff actively encouraged patient feedback to enable them to assess the service they provided. They used patient feedback cards to assess their services. From information they received, staff implemented changes to improve services and we saw various examples of this during our visit of how this directly improved patient outcomes.

# Outpatients and diagnostic imaging

- Earlier in the year, the unit undertook a public listening event with 50 former patients to gain feedback on the service. This event identified some areas for improvement, which the unit has responded to by making changes.
- Information about eye conditions, treatment and the facilities at the eye unit were available on the trust website.
- The unit collected feedback from patients using comment cards, which were analysed by senior nurses to identify areas for improvement.
- Staff at Boston House Eye Unit told us they had not seen any of the trust executive team or senior managers at the site and to their knowledge the site had not been visited by the team.

## **Innovation, improvement and sustainability**

### **Staff engagement**

- Each morning prior to clinics commencing, an informal meeting took place with managers and staff. Any issues or important information were communicated so that all staff were aware and kept up to date with key information. Staff were encouraged to raise any issues they wanted to highlight or any issues of concern to them, which they said they found useful.
- Since moving to Boston House two years ago, the service had continually adapted and evolved to provide patients with an efficient and organised clinic facility.
- Since the unit started Anti-VEGF (vascular endothelial growth factor)' medication injections for the treatment of age related macular degeneration, the demand for the service had increased. Staff told us numbers had grown from single figures to 1,800 in the last six months. There had also been an increase in numbers of patients requiring diabetic retinopathy screening. The unit had identified that whilst it has been able to provide services within its allocated resources, it has been challenging. The unit had completed a bid for further services to accommodate the growth of the service. At the time of our inspection it was not clear whether this had been successful.
- Staff meetings were undertaken every two months. This provided staff the opportunity to express their views and speak to managers and unit leads.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital SHOULD take to improve

- The unit should ensure improvements to quality assurance documentation to record the actions taken to address issues following audits, investigations and action plans.
- The unit should comply with Trust resuscitation policy and use standardised equipment. They should obtain a further defibrillator, an arrest trolley and emergency medicines and provide access to such equipment on both floors of the unit.
- The unit should establish and use a formal process for assessment of mental capacity; this should be documented in patient's notes. They should document their determination of best interests when they undertake this process and record the options and final decision in the patient's records.