

Spamedica Limited

Quality Report

SpaMedica House
43 Churchgate
Bolton
Lancashire
BL1 1HU
Tel:01204 800 838
Website: www.spamedica.co.uk

Date of inspection visit: 16 September 2019
Date of publication: 11/12/2019

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Outstanding



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

SpaMedica Bolton is also the location of SpaMedica headquarters, opening in May 2017, being providers seventh hospital to open. The hospital is based in the centre of Bolton for easy access. They provide NHS funded surgery for cataract, vitreoretinal and YAG capsulotomy (laser), as well as a private service for patients who choose to have refractive correction within their cataract surgery.

We inspected this service using our comprehensive inspection methodology. We carried out this unannounced inspection on 16 September 2019.

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

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

We rated it as **Good** overall.

We found good practice in relation to surgery:

The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Staff worked especially hard to make the patient experience as pleasant as possible.

The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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

Ann Ford
Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating

Good



Summary of each main service

Surgery was the main activity of the service. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated this service as good because it was safe, caring, responsive and well led. We rated effective as outstanding.

Summary of findings

Contents

Summary of this inspection	Page
Background to Spamedica Limited	6
Our inspection team	6
Information about Spamedica Limited	6
The five questions we ask about services and what we found	8
<hr/>	
Detailed findings from this inspection	
Overview of ratings	12
Outstanding practice	30
Areas for improvement	30
<hr/>	

Good 

Spamedica Limited

Services we looked at

Surgery

Summary of this inspection

Background to Spamedica Limited

SpaMedica Limited in Bolton is operated by SpaMedica Ltd. The service opened in 2017 and is the location for the organisations national headquarters. The service primarily serves the communities of Bolton and the surrounding areas of Lancashire and greater Manchester offering cataract surgery and yttrium-aluminium-garnet laser (YAG) capsulotomy services for NHS patients (YAG capsulotomy is a special laser treatment used to improve your vision after cataract surgery). They also accepted

patient referrals from outside this area. The service also accepted self-paying patients at the location. The service has had the current registered manager in post since July 2019, although this person is also the chief operating officer for the organisation.

At the time of the inspection, a change in registered manager had been made and was registered with the CQC in July 2019.

Our inspection team

The team that inspected the service comprised of two CQC inspectors. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about Spamedica Limited

The service had five floors, two floors were the designated clinical areas with the other floors assigned to headquarter operations. The first floor had an operating suite, with one theatre providing cataract surgery, which was the main service provided. The fourth floor housed the outpatient department, where pre and post-operative assessments were provided. The service did not treat children. The service is registered to provide the following regulated activities:

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

During the inspection, we visited the surgery and outpatient areas. We spoke with 20 staff including registered nurses, health care technicians, reception staff, medical staff, optometrist and senior managers. We spoke with 10 patients and two relatives. During our inspection, we reviewed 9 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 service has not been

inspected and this was the services first inspection since registration with CQC, which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (May 2018 to April 2019)

- Between April 2018 to March 2019, there were 4 965 day case operations recorded at the hospital; of these 98% were NHS-funded and 2% other funded.
- There were 5 059 outpatient first attendances and 5 450 follow-up attendances in the reporting period; of these 4% were other funded and 96% were NHS-funded.

Three surgeons worked regularly at the hospital under practising privileges. There were seven registered nurses employed, two optometrists, six healthcare technicians and eight patient co-ordinators.

Track record on safety

- There were no ever events.
- There were no serious incidents, no deaths and no incidents classified as severe harm.
- There were three clinical incidents classified as moderate harm.

Summary of this inspection

- There were 91 clinical incidents classified as either low harm or no harm.

There were no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

There were no incidences of hospital acquired Meticillin-sensitive Staphylococcus aureus (MSSA)

There were no incidences of hospital acquired Clostridium difficile (c.diff)

There were no incidences of hospital acquired E-coli

There were 10 complaints

Services provided at the hospital under service level agreement:

- Decontamination and sterilisation
- Out of hours call handlers
- Pathology
- Interpreter services
- Cleaning
- Clinical waste
- Confidential waste
- Laser Protection Advisor

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?

We rated it as **Good** because:

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

Good



Are services effective?

Are services effective?

Outstanding



Summary of this inspection

We rated it as **Outstanding** because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients that were consistently higher than the national average.
- Key services were available seven days a week, as well as a 24 hour helpline to support timely patient care. Additional appointments were scheduled at weekends to meet patient demand.
- The service made sure staff were competent for their roles.
- Staff offered patients enough food and drink to meet their needs and maintain their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. The service engaged with external stakeholders to enhance the patient experience.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Are services caring?

We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Good



Summary of this inspection

Are services responsive?

Good



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

Are services well-led?

Good



- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and

Summary of this inspection

issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Surgery

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

Are surgery services safe?

Good 

Mandatory training

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

Staff completed annual mandatory training. This was a combination of face to face training and online e learning. There was a requirement for updating of the e learning package on an annual basis. Modules included equality, diversity and human rights, conflict resolution, fire safety, infection control level two, moving and handling level two, safeguarding vulnerable adults level one, safeguarding children level two, basic life support with artificial external defibrillator (AED) and information governance.

Each staff member was required to undertake training to understand the organisations standards in their approach to surgery and optometry, and then work to standards expected.

As the organisation’s headquarters, there were shadowing programmes for new clinical staff with a two day induction. All staff, clinical and non-clinical followed a patient through their journey to help with understanding of the process so they could explain it to patients.

All registered nurses and five of the six health care technicians had completed mandatory e learning modules. Seven of the eight patient co-ordinators had completed mandatory e learning in the 12 months prior to inspection.

Safeguarding

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

Staff completed safeguarding training level one annually and two for adults and children every three years. All patient facing staff were required to complete safeguarding of vulnerable adults level two in addition to other mandatory training. This was completed bi-annually with 100% compliance for both clinical and non-clinical staff.

The current safeguarding lead was available for advice and support and had received safeguarding training to level three. The director of clinical services was a registered nurse and has been booked to attend level four safeguarding training later this year.

There were safeguarding policies in place as well as an NHS safeguarding desktop application on all hospital computers for reference with local contact numbers. The policies included guidance for staff in relation to types of abuse, individual’s roles or responsibilities, what staff should do if a person discloses they are being abused or they suspect abuse; also there was reference to an app held on computers across the organisation with contact details of local authority safeguarding teams.

The safeguarding policy for children, we reviewed, referenced the intercollegiate guidance 2014 rather than the updated 2019 and did not include reference to working together to safeguard children (2018).

In the twelve months prior to inspection, there had been no safeguarding referrals made.

Surgery

Staff we spoke with were aware of their roles and responsibilities in safeguarding and knew how to raise matters of concern appropriately.

Cleanliness, infection control and hygiene

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

There was no meticillin-resistant *Staphylococcus aureus* or meticillin-sensitive *Staphylococcus aureus*, *Clostridium difficile* or *Escherichia coli* reported by the service between May 2018 and April 2019.

All areas visited were visibly clean and free from clutter.

There was an infection control policy that was within the review date that included guidance for staff to follow.

The provider had a designated lead (chief operating officer) along with a nurse lead in infection control.

Personal protective equipment was readily available and included gloves. Appropriate theatre attire was available for surgical procedures. Soap dispensers included 'hand sanitizing techniques' and posters of 'bare below the elbows' were displayed throughout the service.

Wall-mounted hand gel sanitizers were readily available in all areas that included patient rooms. Staff we observed used sanitizing hand gels before providing patient care. All staff we observed adhered to the 'arms bare below the elbows' policy in clinical areas.

Environmental audits were carried out with a compliance standard of 85%. If compliance was below, a re-audit was carried out the following month. In February 2019, there was a compliance of 98% overall and in April 2019 compliance was 99%. Audits covered hand hygiene, environment condition, decontamination in theatre, and sharps management. Actions had included, addition of moisturisers and addition of sharps poster in theatre in case of injury.

The organisation completed water testing monthly to check for any legionella contamination; with the results of a test in September 2019 provided. Senior managers told us that the three areas highlighted red were classified as

low risk and medium priority for action with a planned completion date. This was being monitored by the organisations facility team and the external company. The service had service level agreements in place with external companies for cleaning and laundry services. Manager told us they had no concerns with these services.

Environment and equipment

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

The building had several floors, although there were two lifts and two sets of stairs to each floor. Lifts had raised numbers on control panels and an audible indication of the floor.

Fire instructions and equipment were available on each floor and flooring included yellow stripes on steps.

Access to clinical areas was restricted to staff only requiring swipe card access.

There were resuscitation trollies on the outpatient floor and the surgical floor with a grab bag on the ground floor if needed for other non-clinical areas. Both trollies had daily checks of the top of the trolley checked with a weekly check of the trolley contents. The contents were sealed with tamper proof tags.

Details of lenses used in procedures were added to patient paper records for traceability purposes.

In each room, environmental temperature was checked and recorded daily along with daily check lists for each room. These had been completed in each room visited. In theatre, humidity was checked daily also.

The laser for the service was a YAG laser that treated posterior and anterior capsular opacification. The YAG laser room was locked and accessed by staff only. A sign was displayed, on the door, to indicate when the laser was in use and to indicate to staff not to enter. The temperature of the room was monitored daily, when in use and protective eye wear was available. There was no fire extinguisher, in or close to the laser room. Following the inspection, a risk assessment showed that additional carbon dioxide fire

Surgery

extinguishers, warning lights and locks had been ordered to enhance safety requirements. A register of laser treatments was maintained; however, this did not record all elements as identified in the local rules.

The service had an additional laser that was located in the theatre. This was a femtosecond laser that was used for private patients only. It was used by the surgeon to make a corneal incision and opening in the capsule. In the reporting period, this laser had been operated 20 times. There were additional local rules for this laser although only one surgeon operated the laser. There was signage outside the theatre to restrict access during the operation of the laser.

On the first floor there was a pre admission room, surgical ward, pre theatre area, operating theatre, discharge room and an examination room.

The surgical ward included six chairs, three reclining and three standard. This was a pre-treatment holding area for patients who required topical anaesthesia, prior to surgery.

In the operating theatre planned cataract, vitreoretinal surgery was performed under topical anaesthetic.

In the examination room a slit-lamp was available for ad-hoc examinations as required by the surgeon.

A health care technician was responsible for monitoring supply levels.

There was one operating theatre and outpatient areas for pre and post treatments.

The outpatient facilities were on the fourth floor of the building. They included a diagnostic room, two visual acuity rooms, two pre-assessment rooms, two optometrist rooms and a consultation room.

In the diagnostic room, a health care technician carried out required diagnostic tests.

The consultation room was available for the surgeon for consultations if required.

Information received from the provider showed that equipment had been electrically tested within the twelve months prior to inspection. The service maintained an asset register that included equipment available at the location. Evidence of electrical checks and theatre airflow showed these had been carried out in the twelve months prior to inspection.

Sharps bins were present, in clinical areas. These were dated and all were secure and not over filled.

The provider told us that the uninterrupted power supply (UPS) system was tested weekly by facilities staff. There were plans, following the inspection, to document the checks as part of the daily safety huddle on weekly checklists.

Assessing and responding to patient risk

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

A multi-disciplinary huddle was held each morning in the hospital to plan and review the day's activities.

Risk assessments were carried out for patients including falls, mobility, dementia and anxiety. Patients were assessed to check if could tolerate lying flat during the procedure.

There was a health and safety policy, however; this was past the review date in 2018. The service was reviewing all policies at time of inspection.

There was an exclusion criteria for the location that was aligned to commissioning requirements. Each patient was assessed for suitability on an individual basis. If necessary, patients GP or hospital consultant would be contacted for additional information with the services medical director assessing if the patient was suitable to be treated at the service.

There were organisational care pathways that were individualised for each patient. There were clear sections that highlighted any variances to be aware of. Any allergies were clearly highlighted.

Patients with complex cataracts were included on vitreoretinal operating lists, where only surgeons experienced in responding to complications practiced. Vitreoretinal surgery refers to any operation to treat eye problems involving the retina, macula, and vitreous fluid.

The service did not provide general anaesthetics or patients staying overnight.

The service carried out routine tests during the pre-assessment process. Each patient had a biometry performed. These images take multiple measurements

Surgery

from the eye to calculate the power of the lens that will be implanted during the cataract operation. Ocular coherent topography(OCT) scans were performed on any patient who presented or had previously had any retinal pathology. These scans helped assess a patients suitability for cataract surgery at the service.

The A-scan test measured the length of the patients eye to determine the lens selection for patients with dense cataracts.

Epithelial cell count (ECC) was performed before surgery for patients who were at higher risk of developing corneal issues post operatively.

Patients that presented with corneal problems pre operatively had a corneal topography map to assist with prognosis.

All patients had a detailed eye examination pre-operatively. The images produced could identify other eye related disease for diagnosis.

In the pre admission room, checks were completed by a registered nurse. The eye was dilated in preparation for surgery. Vital signs including blood glucose was checked and pre-assessment details reviewed. Check of consent, diagnostic tests and application of identity and allergy bands, if appropriate as well as the surgical site being marked.

In the pre theatre room the health care technician removed the eye dilator. Patient identity and demographics were checked, as well as consent and diagnostic documents and tests made available for the surgeon. The surgeon introduced themselves to the patient and checked the consent and diagnostic tests in addition to choosing the appropriate intra-ocular lens.

The provider used an adapted version of the World Health Organisations cataract five steps to safer cataract surgery checklist. This checklist is used to ensure safety and help reduce any errors during the surgery.

We observed a cataract procedure and found the checklist was applied and completed appropriately.

An observational audit of the checklist, for 10 patients, showed 97% compliance, although this was not dated.

Auto-refractor was used on every patient that attended out-patient post-operative clinic. This assessed patients refractive outcome, to monitor if within their target aim post operatively.

The lists were populated with routine cataract extraction and intra-ocular lens implanted in addition to vitreoretinal surgery. There could be up to 25 patients on each list. The theatre team took a lunch break after the morning list which was usually patient number 14.

Two registered nurses had completed advanced life support (ALS) training, including the area manager, and all seven registered nurses had completed immediate life support (ILS) training within the twelve months prior to inspection. Five of the six healthcare technicians had completed basic life support in the twelve months prior to inspection. Seven of the eight patient co-ordinators had completed basic life support within twelve months of the inspection. The medical director had completed ALS and the lead optometrist, who was the laser protection supervisor had completed ILS.

There was a resuscitation policy that was within the review date.

In the reporting period of April 2018 to March 2019, there had been no transfers to a neighbouring NHS trust. There was no formal agreement with the trust. In an emergency situation, the provider would call 999.

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

A 24/7 on call-service was available, following discharge for additional support. Experienced optometrists triaged calls and referred patients to an on-call consultant and registered nurse if treatment was required at any time out of hours.

There were standardised emergency endophthalmitis kits available at the hospital if needed. These kits include treatments for initial management of bacterial endophthalmitis which a severe inflammation of the tissues inside the eye is due to infection.

Trained nurses had completed either advanced life support training or immediate life support training. An audit of one

Surgery

of the resuscitation trollies was carried out in August along with an unannounced simulation of an arrest scenario. It was found that staff performed to a satisfactory standard and all necessary equipment was available.

Staffing

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

Hospital managers liaised across the region to support and plan staffing. Patient activity was shared in advance to hospital sites to enable forward planning of off duty.

The organisation had agreed minimum staffing for the hospitals and they could only proceed when the standard of skill-mix was confirmed.

The organisation ensured that the staffing team had appropriate skills and if considered that a team required additional resources due to the potential complexities of the service or skill-mix of team members, staffing was increased to ensure that the clinical staff were suitably supported.

Team members were only considered 'in numbers' once they were deemed competent to ensure clinical quality and patient care was of the highest standard.

There was a higher number of health care technicians at this hospital with a senior experienced technician, who supported the registered staff.

A new post of clinical coordinator was created to support self-paying patients.

As a minimum requirement hospitals were planned with: we will run the following clinics with an ophthalmic surgeon, two registered nurses, two scrub nurses and two health care technicians in theatre, an optometrist, a registered nurse and two health care technicians in the pre-assessment clinic, an optometrist, a registered general nurse and two health care technicians in the post-operative clinic and two registered nurses with three health care technicians in the age related macular degeneration clinic.

There was a total of 24 staff employed at the hospital including registered nurses and health care technicians as well as support staff.

From May 2018 to April 2019, there was an average of 18.8% registered nurse bank / agency staff employed per month in theatre. Any new agency staff were required to complete an induction and have competencies signed off before providing any patient care or treatment.

The average sickness rate, for the same period, across all staff was on average 0.1% per month and average turnover of 1% per month. There was one vacancy, for a theatre registered staff member, although staffing was planned across the organisation but mainly buddied with another location.

There were two optometrists who supported the ophthalmologist.

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

Medical staffing

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

All ophthalmic surgeons were reviewed by the medical director to ensure the appropriate practising privileges were completed and in place. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services.

For the reporting period of May 2018 to April 2019, there were 17 doctors employed via a practising privileges arrangement. Of these six had carried out between 10 and 99 episodes of care and 11 had carried out 100 or more episodes of care.

At the time of inspection, the provider confirmed that there were three consultants who regularly operated at this location with an additional four doctors who worked on an ad-hoc basis.

Surgery

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

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

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

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

There was a business continuity plan in place to safeguard records should there be any electronic or power outages.

Records were stored securely in the reception area and transferred to locked area at the end of day.

Monitors could only be viewed by reception staff.

Records followed patients and stayed in rooms with staff.

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

A records audit, in July 2019 was carried out where 10 patient records were reviewed. There was 86% compliance. Areas of non-compliance included dating and signing of paper prescription chart as well as the dating of the WHO checklist and printing name. The plan was to re-audit in September.

Medical records were only removed from site in secure locked transport carriage boxes at pre-arranged times by the organisations internal transport service. The recipient confirmed receipt of the patient record as soon as it arrived by signing the file transfer form at the required hospital location. Records did not remain in vehicles overnight. Each transferred patient record was recorded by

completing a file transfer form. Only staff with agreed access to patient records had the authority to transfer a patient record. Each patient record was entered on the organisations patient administration system (PAS) system with the date the request of transfer and the date received at specified location. Confirmation the patient record had been stored in the patient records area of the required location was also recorded. All paper records of discharged patients were scanned and indexed to be retrieved on request for planned follow up appointments. All clinical diagnoses and episodes of treatment records were stored electronically and were available at all sites in the case of an unplanned follow up.

Where necessary, it was possible for patient records to be sent externally by courier. Each record was sealed with tape and placed in a robust envelope clearly addressed to a named individual and marked "private and confidential" and sent using recorded delivery service. The senders name was also clearly marked on the reverse of the envelope for identification purposes. A log of all records dispatched from our patient records department included the date sent, name, designation and location of person to whom the records were sent, service username and volume of records sent.

Confidential waste was placed in shredding bins and removed by an external company via a service level agreement.

Medicines

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

The service used topical and local anaesthesia to the eye only. Drops were prescribed using patient specific directions (PSD). These were administered by health care technicians who recorded on the paper PSD and also in the patients electronic record. We observed that the paper record was either ticked or abbreviations used to indicate given. We addressed this on-site and were told that after the inspection, staff were reminded to include full signatures.

The medicines management policy was reviewed and referred to patient group directions as well as PSD's. The company were planning to implement PGD's following agreement from local commissioning authorities. A patient group direction (PGD) is a written instruction that includes

Surgery

the administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The service had plans to introduce PGD's following consultations with commissioners.

The service stored diazepam to be available for patients who were identified as anxious prior to surgery. It was stored appropriately and records completed for checking and administration. The prescribing of diazepam was included on the prescription chart with other medicines given following PSD's. From the chart it was not clear when it was administered. We addressed this on-site and the chart was amended with diazepam clearly shown including time of administration. This was the only medicine stored as a controlled drug.

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

There was no controlled drug accountable officer (CDAO) at time of inspection although training has been planned for November 2019 for hospital and area managers within the organisation.

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

The temperature of the clinical fridge was monitored and recorded appropriately, including the maximum and minimum ranges.

A medicines audit was carried out in July 2019, by the external pharmacy company where a number of recommendations were made. The action plan showed that all actions had been completed. There were plans to increase internal pharmacy audits later in the year.

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

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Incidents and near misses were recorded on an electronic reporting system.

In the reporting period of April 2018 to March 2019, there were no never events or serious incidents. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic barriers are available as at a national level and should have been implemented by all healthcare providers.

There was a hospital total of 94 clinical incidents reported, of which 91 were classified as either low harm or no harm.

Of these incidents, 53 were for surgery and 15 were for outpatients.

There had been two incidents reported as non-clinical.

The service used a root cause analysis approach for investigations of incidents and the manager had received training to complete these. Themes and trends were reviewed with any learning shared through clinical governance, medical advisory (MAC) and health & safety committees.

Team meeting minutes we reviewed including the sharing of incidents across the organisation.

There was a policy for critical incident reporting and management with a review date of 2020 and there was serious untoward incident policy, however; this was past the review date of April 2019.

There was a duty of candour policy. (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person). Staff we spoke with understood that duty of candour was about being open and transparent with patients and those close to them.

Are surgery services effective?

Outstanding



Evidence-based care and treatment

Surgery

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

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

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

The service carried out quarterly clinical audits that covered key topics. Any audits that were less than 85% compliant, had actions identified, and the audit was repeated one month later.

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

Waiting times from time of arrival to departure through each stage of the patient journey were monitored as part of key performance indicators to monitor and action if there are areas that need addressing.

An audit of the local rules had taken place, in May 2019, with recommendations following the audit. A current action plan was received, however; this did not refer to the recommendations included in the LPA audit.

Nutrition and Hydration

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

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

Pain relief

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

Local anaesthesia was administered during the presurgical procedure.

Patients we spoke with told us the procedure was pain-free.

Pain audits were completed immediately after discharge, by reception staff in face to face discussion and through a questionnaire which fed into the patient reported outcome measures (PROMS).

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make^[LD1] improvements and achieved good outcomes for patients that were consistently higher than the national average.

Data was submitted to the National Ophthalmic Database Audit. For 2018: the posterior capsular rupture rate (PCR) was 0.4%. This was significantly better than the UK national average which was 1.1%. The significant loss of vision score was 0.4%. This was a better result than the UK standard of less than 0.9%. For visual acuity of 6/12, the outcome was 96.1%. This was better than RCOphth guidelines for visual acuity of 6/12 which was 95%. RCOphth guidelines for +/- 1.00D was 85%; SpaMedica was better than this guideline at 91.18%.

For quarter one of 2019, visual acuity >6/12 was 94.86%; the national standard was >95%, visual harm was 0.3%; this was better than the national standard of less than 0.9% and endophthalmitis was 0%; the national standard was <0.03%.

The provider also monitored post-operative complications, although there was no national standard for these complications. For the same time period; post-operative uveitis was 7.03%, cystoid macular oedema was 2.61%, corneal oedema was 1.8%.

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

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

In the reporting period, there were three unplanned returns to theatre following complications of surgery, who recovered and were discharged following the follow-up. Three further patients had planned returns to theatre following the complexities of the first surgical procedure.

Competent staff

Surgery

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

Staff did not practice in any role until assessed as competent. Every new staff member shadowed patient's through their treatment journey as part of their induction to ensure they are more understanding of what patients experience.

The service maintained a skills matrix that indicated staff who had been trained and deemed competent for certain roles and responsibilities.

There were nine members of staff who had completed core of knowledge training with three staff members booked for October.

In the reporting period of May 2018 to April 2019, all staff had received an appraisal.

Two of the five registered nurses had degree qualifications in ophthalmic nursing. In response to increased activity, skills of registered nurses had increased to include surgical scrub.

All staff were required to attend a core of knowledge course with an external provider. This was routinely refreshed every three years, although would be less if any concern was highlighted. An external laser protection advisor (LPA) had been identified who had developed the local rules for the location. The nominated laser protection supervisor (LPS) had completed level four training in laser treatment that included face to face and e learning elements. There was no nominated deputy for the LPS although staff with appropriate skills and training could be re-deployed from other locations across the region.

Staff were supported to develop their roles and this was reflected in the staff survey in May 2018.

In the visual acuity rooms, tests, intra-ocular pressure tests and dilation of the eye were completed by health care technicians.

In the pre assessment rooms, a registered nurse took a full medical, surgical and ophthalmic history including any prescribed medicines and any allergies. Blood pressure and blood glucose taken (if indicated). Patient was then provided with written booklet of what to expect, if not already received via post, in addition to a verbal overview.

In the optometrist rooms, a slit-lamp examination was completed by the optometrist. If appropriate for surgery, written consent was obtained. An explanation was provided of what to expect and then escorted to reception to agree a surgery date.

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

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

There were plans to offer NHS surgeons opportunities to gain experience with the provider.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was effective working between all staff, that we observed, at the location with good teamwork.

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

The service worked well with external stakeholders including commissioners and G.P.'s as well as private optometry services.

Seven-day services

Key services were available seven days a week, as well as a 24 hour helpline to support timely care. Additional appointments were scheduled at weekends to meet patient demand.

Depending on the demands for the service, additional surgical lists could be planned for weekends. The rotas reviewed included planned weekend activities for both Saturday and Sunday.

The emergency helpline was available 24 hours a day, seven days a week and the dedicated call centre was

Surgery

staffed from 8am to 6pm Monday to Saturday. Patients were informed verbally and in writing in their discharge information. An on-call team were available to provide advice

Health Promotion

Staff gave patients practical support and advice to lead healthier lives

Patients were given discharge advice both verbally and written leaflets.

Information including advice about keeping the eye clean as well as driving or operating machinery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The organisation had a Mental Capacity Act policy that was within the date of review and included guidance for staff to follow. The policy included guidance for patients assessed as lacking capacity to consent such as involvement of an independent mental capacity act advisor (IMCA). There was a consent policy with a review date of September 2019.

Prior to the procedure, patients received written information in the post.

We observed staff obtaining verbal consent from patients before providing care. The service did not treat children.

The service had a two-stage consent process by obtaining written consent at pre-assessment which was re-confirmed on the day of the procedure.

Written consent was obtained before surgery and recorded in the patients paper records. Optometrists had completed Mental Capacity Act 2005 (MCA) and consent training. We observed an optometrist who was very thorough in gaining informed consent from a patient providing options available to them.

If staff assessed that patients were unable to consent to treatment, they would discuss with families and the referrer to review the most appropriate location for any treatment agreed. There was no process, however; for an independent mental capacity advocate (IMCA) in place.

Mental Capacity Act 2005 and deprivation of liberty safeguards training level two and three was mandatory for all patient-facing staff. This was completed bi-annually and there was 100% compliance for both clinical and non-clinical staff.

There was an interpreter service available to help with consent for patients whose first language was not English. These were pre-booked to provide either face to face or telephone support. Staff told us family members were not used for consent purposes.

Are surgery services caring?

Good 

Compassionate care

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

We observed staff interacting positively with patients and those close to them. These included medical staff, allied health professionals and support staff as well as nurses. Staff spoke to patients sensitively and appropriately depending on individual need.

Staff introduced themselves and communicated well to ensure patients fully understood. Patients were encouraged to ask questions and were given time to ensure they understood what was being said to them.

The service requested patient feedback immediately post-surgery, on leaving the hospital and during community optometrist checks. as well as carried focus groups to obtain more feedback from patients.

Feedback was shared through weekly email updates and monthly newsletters with staff.

Compliments were recorded on the organisations electronic reporting system,

Surgery

The service submitted feedback data to the NHS Friends and Family Test. Between November 2018 and April 2019, 99.3% of patients would recommend the service, with a response rate of 98.6%.

We observed three patients, during clinic preassessment consultations and two patients on the day of surgery, with different staff members. All introduced themselves and explained all care and treatment either to patients alone or accompanied by a relative.

We spoke with 10 patients and two relatives. All those we spoke with were very positive about their experience and care received. They had all been given a choice of where to go for care. They were told that they would have long waiting times for their local NHS hospitals whereas they would only need to wait two or three weeks if chose SpaMedica. Patients spoke highly of all the staff, through their treatments with some returning patients for their other eye.

All clinic consultations were held in private rooms although there was no signage to indicate if a patient was in the room. This meant staff needed to knock on doors and entered to leave notes.

Emotional support

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

Staff members were available to support patients during treatments.

We observed staff providing reassurance and comfort to patients both in private consultations and also during the surgical procedure. Staff were calm and supportive providing extra time to these patients.

Patients were provided with the organisations "patient stories" DVD where previous patients described their experience to help relieve anxiety. Videos were included in the organisations website.

If a patient was assessed to be very anxious, they could be prescribed a medicine to help with the nervousness.

Understanding and involvement of patients and those close to them

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

Staff respected patient choices and delivered their care with an individualised person centred approach.

There was a chaperone policy in place. Patients could be accompanied by someone close to them in clinics and theatres; "hand holders" were made available for extra support if needed. We did not see any posters regarding chaperones.

Patients and those close to them told us that they received information in a manner that they understood before and after the procedure.

Are surgery services responsive?

Good 

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. Facilities and premises were appropriate for the services being delivered.

Between April 2018 to March 2019, there were 4 965 day case operations recorded at the hospital; of these 98% were NHS-funded and 2% other funded.

There were 5 059 outpatient first attendances and 5 450 follow-up attendances in the same period; of these 4% were other funded and 96% were NHS-funded.

In the reporting period, there were 20 intraocular lens replacements carried out.

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

Patients were from the local area, although some had travelled across the county as they were told waiting times were shorter than if they attended their local NHS hospital.

Surgery

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

There was free car parking facilities at the location and it was situated in the centre of town.

The service was routinely open six days per week, although extra lists were added when there was an increased demand.

The provider website included patient stories that could be viewed at home. Alternatively free DVD's were available for patients to take home and watch prior to their planned surgery.

Free refreshments of hot and cold drinks and biscuits were available during any hospital visit. A television displayed the news, including subtitles as well as a range of magazines.

The hospital operating times were between the hours of 7.30am to the end of the surgical list, which on average was completed by 6pm.

The organisations helpline was available 24 hours a day, seven days a week for patients following discharge. On average the organisation received 10,000 calls a month, some of which were patients, not treated by the organisation, who called for general advice.

Meeting people's individual needs

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

There were two lifts available for patients with reduced mobility. Each floor had a designated place of safety that included an intercom system, although an evacuation chair was available if appropriate in the event of an emergency evacuation.

The service could accommodate bariatric patients on the theatre operating table, although patients needed to be able to transfer onto the table independently.

Wheelchairs were available for patient use if required. There was a range of chairs in the waiting room; some with arms and others without.

The service had two dementia champions, a registered nurse and a health care technician, who had completed dementia training.

Free patient and carer transport was offered within a 10 to 30 mile range of the hospital with patients safety to travel risk assessed individually. Drivers collected patients from their home with a reminder the day before of the expected time.

For patients with longer distances to travel, larger vehicles with toilet facilities and refreshments were provided.

If patients were delayed at the hospital, taxis, free of charge were provided for their journey home.

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

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

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

There was a separate waiting area for self-paying patients; we did not see any patients at the time of inspection.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to treat and discharge patients were better than national standards.

Referrals were received by phone and patients were contacted within 48 hours to book an appointment for a pre-assessment clinic.

The services referral to treatment target was six to seven weeks. A weekly activity meeting was held that monitored this and additional theatre sessions were created to meet the demand.

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

Managers monitored and took action to minimise missed appointments.

Surgery

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

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

Patients were offered a choice of appointment, including weekends. The services referral to treatment target was six to seven weeks. Between May 2018 and April 2019, the average waiting time from referral to pre-assessment clinic was 22 days. For the same time period, the average waiting time between pre-assessment clinic and surgery was 23 days.

In the 12 months prior to inspection, there were 33 patients cancelled for non-clinical reasons, 18 of which were re-booked within 28 days of the cancelled appointment.

Waiting times were monitored from time of arrival and departure times from each stage of the patient journey. Between May 2018 and April 2019, the time to be seen in pre-assessment clinic was an average of 16.9 minutes and the post-operative clinic wait time was on average 15.6 minutes. The treatment wait time was an average of 23.3 minutes.

Between May 2018 and April 2019, the average time to be seen in the laser pre assessment clinic was 13.5 minutes and treatment wait time was on average 7.6 minutes.

Waiting times were displayed in reception areas for patients to see.

In the discharge room a registered nurse checked the patient's blood pressure and provided the patient with discharge information and guidance both verbally and in writing.

Learning from complaints and concerns

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

There was a complaints policy in place which was accessible to all staff.

A patient complaints leaflets was available in all reception areas that advised the patient of the ways in which they could provide feedback or submit a complaint. The leaflet did not include details of how to signpost to another organisation such as the Parliamentary and Health Service Ombudsman (PHSO) for NHS patients or the Independent Sector Complaints Adjudication Service (ISCAS) for self-paying patients. The website did include details for the PHSO and the organisation were reprinting leaflets to include this information.

In the reporting period of April 2018 to March 2019 the service received 10 complaints.

Once a complaint was received it was added to the organisations electronic reporting system and allocated to the hospital manager.

The organisation had a timescale of three working days for the initial acknowledgment of the complaint. The hospital managers then had 20 working days to complete an investigation and provide a detailed response. If more time was required, then an update was issued to the patient to make them aware of the revised timeframe. The organisation aim to complete a complaint within the 20 working days and it was only where there was a complex complaint where the investigation is lengthy. While the complaints information was being amended, managers had been directed to include PHSO information in any response.

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

Examples of changes made following feedback from staff included the purchases of bariatric wheelchairs and waiting room chairs with arm rests.

Surgery

Are surgery services well-led?

Good 

Leadership

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

The service had recently appointed a new hospital manager who was an experienced current employee. There was a planned period of training, induction and mentorship with an increased presence from the experienced area manager and senior leadership team to support the manager.

In response to recent changes of staff members the service had increased visibility from the senior team including the area manager. Staff we spoke with told us managers were visible and approachable.

The hospital managers told us they felt supported within their roles by all levels of management.

Vision and strategy

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

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

The organisations values was included in the induction for all staff.

Staff we spoke with were clear about the vision and values for the organisation.

Visions and values were included as part of the organisations website.

A clinical governance strategy for 2019/20 was in place to enhance effective governance and culture using clinical quality key performance indicators.

Culture

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

There was a positive attitude and culture where staff valued each other. Staff reported good team working and a sense of pride providing continuity of care using a team approach.

Senior managers were based at the location and were visible to staff.

All staff, we spoke with, were proud and passionate about the service they provided.

Staff we spoke with had been employed for varying lengths of time with recently appointed staff reporting feeling supported by their managers to discuss ways of improving services to provide quality care for patients.

Staff told us they felt valued and appreciated by the senior managers.

During our inspection we observed positive interactions between all levels of staff and patients.

Governance

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

There was a process and policy in place to monitor and review practising privileges for medical practitioners to ensure standards were adhered and concerns escalated. This had been reviewed by the medical advisory committee (MAC). Surgeons were interviewed and their outcomes for patients reviewed prior to forwarding recruitment

Surgery

documentation. New applications were received with a process where individual applicants were reviewed and accepted to supervised practice assessment, before having practising rights approved. The lead surgeon observed the applicants during a trial operation list followed by supervision with a limited number of patients initially increasing to a maximum of 24.

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

The laser protection adviser (LPA) was available to provide support and guidance regarding the use of the laser. We reviewed a copy of the LPA certificate; this was current, although; the name of the LPA was included in the training companies list of radiation protection adviser's (RPA) rather than LPA's.

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

Complaints were monitored by the executive assistants, chief operating officer and director of clinical services. The process and emerging themes are discussed where appropriate at the clinical governance committee.

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

Audit outcomes were discussed at monthly board meetings.

As part of the organisations clinical governance strategy there was a planned review of the policies, procedures and processes.

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

There was a service level agreement in place with the laser protection advisor (LPA). Local rules were in place that all staff who operated the YAG laser were required to read and sign.

We reviewed a sample of employment files, during the inspection, and found that references were not always present for staff who had been employed for a number of years.

We reviewed an example of a surgeon who had been recently accepted via practising privileges that showed all checks had been completed prior to being given a start date. We addressed this on-site and following the inspection, the provider introduced a risk assessment to ensure that when there was variance from the standard recruitment checks they could assess the risk to ensure patient safety. The recruitment policy was amended to reflect the changes that included reference and health checks.

Following the inspection, evidence of director fit and proper persons checks was provided that showed background checks carried out for senior staff. All directors and board members have had good standing checks performed and evidenced as satisfactory.

Service level agreements were in place for support services including out of hours call centre, interpreting services, disposal of confidential waste, cleaning and housekeeping, pharmacy and decontamination of surgical equipment. Some agreements included amendment details, however; in the copies provided, not all were signed by both parties and it was not always clear if contracts were indefinite with start dates longer than one year.

Managing risks, issues and performance

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

There was a risk register that was reviewed and updated by the hospital and area managers. Risks had been identified with control measures in place to help reduce any risk although these were potential risks rather than current identified risks. There were dates for review of the risks, however; there was no information about when a risk was first identified.

Senior managers were committed to providing quality care for patients. Surgical performance was monitored

Surgery

quarterly, on a dashboard that included outcomes of surgery and bedside manner using a rag rated system. Examples were provided where surgeons had been identified as requiring additional support when to improve scores.

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

There was a business continuity plan in place to safeguard records should there be any electronic or power outages.

Managing information

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

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

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

Minutes from operational meetings included concerns about data breaches across the organisation, such as letters being sent out with other patient letters and also theatre list in with these letters.

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

Engagement

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

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

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

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

Patient feedback was then obtained, specifically on bedside manner and patient experience in theatre.

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

The organisation liaised with local charities to support continued care in the community.

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

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

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

Learning, continuous improvement and innovation

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

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

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

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

Surgery

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

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

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

Outstanding practice and areas for improvement

Outstanding practice

The service achieved good outcomes, that were continuously monitored, with patients reporting a positive experience.

The service had an endophthalmitis box on site in case of an emergency.

Patients stories were available as DVD's or on the website

The service provided free transport to patients who lived within a set distance from the location.

The service offered an accreditation scheme for community optometrists

The medical director was passionate about the service and had completed research studies.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that local rules and any recommendations from the authorised laser protection advisor are followed safely.
- The provider should ensure that the safeguarding policy for children references current guidance.
- The provider should consider alternative formats for leaflets and website information.
- The provider should consider how to indicate a room is occupied to help prevent interrupting appointments.
- The provider should consider posters to indicate a chaperone is available.
- The provider should consider reviewing service level agreements in line with best practice.
- The provider should consider revising the risk register to evidence date added and review.